

IN THE UNITED STATES COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION MDL NO. 2804  
OPIATE LITIGATION

Case No. 17-mdl-284  
Judge Dan Polster

This document relates to:  
The County of Summit, Ohio, et al.,  
V.  
Purdue Pharma L.P., et al.,  
Case No. 1:18-OP-45090 (N.D. Ohio)

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Videotaped deposition of
DOUGLAS A. SMITH, M.D., DFAPA
November 16, 2018
9:08 a.m.

Taken at:
Jackson Kelly PLLC
50 South Main Street Street
Akron, Ohio
Wendy L. Klauss, RPR

1 APPEARANCES:

2
3 On behalf of the City of Akron, Summit
County, and the Witness:

4 Motley Rice LLC
ANNE MCGINNESS KEARSE, ESQ.
ANNIE E. KOUBA, ESQ.
5 JODI WESTBROOK FLOWERS, ESQ.
28 Bridgeside Boulevard
6 Mt. Pleasant, SC 29464
(843) 216-9140
7 Akearse@motleyrice.com
Akouba@motleyrice.com
8 Jflowers@motleyrice.com

9 On behalf of Cardinal Health, Inc.,
Co-Liaison Counsel for the Distributor
10 Defendants:

11 Williams & Connolly LLP
PAUL BOEHM, ESQ.
BRAD MASTERS, ESQ.
12 MELINDA JOHNSON, ESQ.
725 Twelfth Street, N.W.
13 Washington, DC 20005
(202) 434-5000
14 Pboehm@wc.com
Bmasters@wc.com
15 Mkjohnson@wc.com

16 On behalf of Walmart Inc. F/K/A Wal-Mart
Stores, Inc.

17 Jones Day
EDWARD M. CARTER, ESQ.
18 325 John H. McConnell Blvd.
Suite 600
19 Columbus, OH 43215-2673
(614) 469-3939
20 Emcarter@jonesday.com

-AND-

21 Jones Day
MEREDITH KINCAID, ESQ.
22 1420 Peachtree Street, N.E.
Suite 800
23 Atlanta, GA 30309-3053
(404) 581-3939
24 Mkincaid@jonesday.com
25

1 APPEARANCES, Continued:

2 On behalf of Teva Pharmaceutical
Industries Ltd.:

3 Morgan Lewis, LLP
WENDY WEST FEINSTEIN, ESQ.
4 One Oxford Centre, 32nd Floor
301 Grant Street
5 Pittsburgh, PA 15219-6401
(412) 471-3490
6 Wendy.feinstein@morganlewis.com

7 On behalf of the Distributor Defendant
McKesson Corporation:

8 Covington & Burling LLP
BRYANT PULSIPHER, ESQ.
9 One Front Street
San Francisco, CA 94111-5356
10 (415) 591-6000
Bpulsipher@cov.com

11 On behalf of Johnson & Johnson and
12 Janssen Pharmaceuticals, Inc.:

Tucker Ellis, LLP
13 TARIQ M. NAEEM, ESQ.
RACHEL N. BYRNES, ESQ.
14 950 Main Avenue, Suite 1100
Cleveland, OH 44113
15 (216) 592-5000
Tariq.naeem@tuckerellis.com
16 Rachel.byrnese@tuckerellis.com

17 On behalf of the Allergan Finance, LLC:

18 Kirkland & Ellis LLP
TUCKER HUNTER, ESQ.
19 300 North LaSalle
Chicago, IL 60654
20 (312) 862-2000
Tucker.hunter@kirkland.com

21 On behalf of Teva Pharmaceutical
22 Industries Ltd.:

Morgan, Lewis & Bockius
23 ZACHARY A. LAZAR, ESQ.
77 West Wacker Drive
24 Chicago, IL 60601-5094
(312) 324-0000
25 Zachary.lazar@morganlewis.com

1 APPEARANCES, Continued:

2 On behalf of Endo Health Solutions, Inc.,
3 Endo Pharmaceuticals Inc., Par
4 Pharmaceutical, Inc., and Par
Pharmaceutical Companies, Inc., (FKA Par
Pharmaceutical Holdings, Inc.)

Arnold & Porter
5 NEDA HAJIAN, ESQ.
777 south Figueroa Street
6 44th Floor
Los Angeles, CA 90017-5844
7 (213) 243-4000
Neda.Hajian@arnoldporter.com

8
On behalf of Distributor
9 AmerisourceBergen Drug Corporation
Reed Smith, LLP
10 ANNE ROLLINS, ESQ.
Three Logan Square
11 1717 Arch Street, Suite 3100
Philadelphia, PA 19103
12 (215) 851-8100
Arollins@reedsmith.com

13 ~ ~ ~ ~ ~

14 ALSO PRESENT:

Jim Torok, Videographer

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18
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1 THE VIDEOGRAPHER: We are on the
2 record. Today's date is November 16, 2018.
3 The time is approximately 9:08 a.m.

4 We are here to take the videotaped
5 deposition of Doug Smith, in the case of
6 National Prescription Opiate Litigation, case
7 number 17 MD 2804, to be heard in the United
8 States District Court, Northern of District of
9 Ohio, Eastern Division.

10 Would counsel please state their
11 appearances for the record.

12 MS. KEARSE: Anne Kearse, with
13 Motley Rice, on behalf of the County of Summit
14 and City of Akron.

15 MS. KOUBA: Annie Kouba, of Motley
16 Rice, on behalf of the County of Summit and the
17 City of Akron.

18 MS. FLOWER: Jodi Flowers, Motley
19 Rice, on behalf of the County of Summit, the
20 City of Akron, and the witness.

21 MR. CARTER: Edward Carter,
22 Walmart.

23 MS. KINCAID: Meredith Kincaid,
24 Walmart.

25 MR. BOEHM: Paul Boehm, from

1 Williams & Connolly, for Cardinal Health, and
2 I'm joined by Brad Masters and Mindy Smith.

3 MS. WEST FEINSTEIN: Wendy West
4 Feinstein, with Morgan Lewis, on behalf of the
5 Teva defendants.

6 THE NOTARY: On the phone, please.

7 MR. BOEHM: I'm sorry. I said
8 Mindy Smith, but I meant Mindy Johnson. I'm so
9 sorry, Mindy.

10 MR. LAZAR: Good morning. This is
11 Zach Lazar, from Morgan Lewis, on behalf of the
12 Teva Defendants.

13 MR. HUNTER: Tucker Hunter, from
14 Kirtland & Ellis, on behalf of Allergan
15 Finance.

16 MR. NAEEM: Tariq Naeem, on behalf
17 of Janssen and Johnson & Johnson.

18 MS. HAJIAN: Neda Hajian, from
19 Arnold & Porter, on behalf of the Endo and Par.

20 MS. ROLLINS: Anne Rollins, from
21 Reed Smith, on behalf of AmerisourceBergen Drug
22 Corporation.

23 MR. PULSIPHER: Bryant Pulsipher,
24 Covington & Burling, for McKesson.

25 THE VIDEOGRAPHER: Please swear the

1 witness.

2 DOUGLAS A. SMITH, M.D., DFAPA, of
3 lawful age, called for examination, as provided
4 by the Statute, being by me first duly sworn,
5 as hereinafter certified, deposed and said as
6 follows:

7 EXAMINATION OF DOUGLAS A. SMITH, M.D., DFAPA
8 BY MR. BOEHM:

9 Q. Good morning, Dr. Smith.

10 A. Good morning.

11 Q. You and I introduced ourselves off
12 the record, but we will do it formally again on
13 the record. Thank you for being here this
14 morning.

15 Could you please state and spell
16 your name, just for the record.

17 A. Sure. Douglas Smith,
18 D-O-U-G-L-A-S, Smith, S-M-I-T-H.

19 Q. And what is your address?

20 A. 1867 West Market Street, Akron,
21 Ohio.

22 Q. What is your understanding as to
23 why you have been asked to give deposition
24 testimony here today?

25 A. Well, I work with the Summit County

1 Alcohol, Drug Addiction, Mental Health Services
2 Board, and in my role since May 1 of 2012, part
3 of that role has involved the -- working with
4 the opiate epidemic and, as a result of that, I
5 guess I have certain facts that are important
6 to the case.

7 Q. Have you read the complaint that's
8 been filed in this case?

9 A. No. I did try to glance at the
10 table of contents, but I actually didn't read
11 the -- I got a sense of how broad it is.

12 Q. Did you have an opportunity to
13 review the complaint before it was filed?

14 A. No.

15 Q. Nobody asked you to look it over?

16 A. Never.

17 Q. Do you know who wrote the
18 complaint?

19 A. I don't think that -- I literally
20 looked at it two days ago, so I don't think I
21 know who wrote it, no.

22 Q. When did you first learn that this
23 lawsuit was going to be filed?

24 A. We had a -- so ADM board has a
25 board of directors, and we had a meeting with

1 them -- well, actually, I had to leave the room
2 because our director, Jerry Craig, was in the
3 room, but they had -- they went into executive
4 session.

5 This was probably, geez, it might
6 even be early in 2018, not real long ago, and
7 they met to determine whether ADM was
8 officially part of the County of Summit for
9 this purpose, because we are kind of separate,
10 because we have our own board of directors.

11 But anyway, somewhere, it wasn't
12 real, real long ago, it might have been -- it
13 probably was from our board meetings in 18.

14 Q. So is that meeting sometime in
15 early 2018 the first time you learned about the
16 existence of this lawsuit?

17 A. Yes. It was pertaining to us, yes.
18 I had heard, you know, through the media that
19 at some point there might be a lawsuit, but I
20 didn't think about it much and certainly didn't
21 expect we might be first.

22 Q. You said the purpose of lawsuit --
23 or I'm sorry -- the purpose of that meeting
24 that you recall was to determine whether or not
25 the ADM board was part of Summit County or not?

1 A. Because of the weird -- and I don't
2 pretend to understand it, I'm not the director,
3 and I don't deal with anything nonclinical, so
4 I think it is just to make sure that we were
5 going to be working with the Count of Summit
6 together, as part of the fact finding.

7 Q. Is the ADM Board for Summit County
8 a part of county government?

9 A. We are, but as -- not 100 percent,
10 because our director reports to a board of
11 trustees, as opposed to reporting to our county
12 executive.

13 Q. When you say, "Not 100 percent,"
14 can you tell us more what you mean by that?

15 A. I just did. That's all I know. So
16 in other words, some departments report
17 directly to the county executive, and ADM does
18 not report directly to the county executive,
19 because we have a structure of 14 board
20 members, appointed by both the county and the
21 state, that sit on the board, and then our
22 director reports to them. He does not answer
23 to the county executive.

24 Q. You said that you had to leave the
25 room at that meeting?

1 A. When they go into executive
2 session, that means it is Jerry Craig, our
3 director, and the board members, and then if
4 they had invited guests, whoever they were.

5 So they have a discussion that's
6 not public. Otherwise, our meetings are
7 public.

8 Q. Understood. So when you talk about
9 the board, you are talking about the board of
10 directors for the Summit County ADM Board?

11 A. Correct. It's confusing. We've
12 used the board twice, but, yes.

13 Q. And you are not a member of the ADM
14 Board board of directors?

15 A. Correct. I'm a staff member.

16 Q. And do you know what the
17 determination that was -- let me strike that
18 and start over.

19 Do you know what determination was
20 made at that meeting as to the question of
21 whether or not the Summit County ADM Board
22 would be considered part of Summit County for
23 purposes of this lawsuit?

24 MR. KEARSE: Object to form.

25 A. I believe the answer was yes,

1 because I'm here today talking to you, so...

2 Q. Did you have an opinion about that?

3 A. Not at all. That's not clinical.
4 Everything I do is clinical.

5 Q. Has anybody ever asked your opinion
6 about whether or not this lawsuit should be
7 filed?

8 A. Nobody.

9 Q. Do you have an opinion about that?

10 MR. KEARSE: Object to form.

11 A. I have never really given it
12 thought. I under -- having grown up in the
13 Baltimore/DC area, I was aware of, like, the
14 big asbestos cases and those kind of things.
15 So I kind of understand a little bit about
16 class action, but I don't have an opinion about
17 the lawsuit, per se.

18 Q. Do you know whose decision it was,
19 ultimately, to file the lawsuit on behalf of
20 Summit County?

21 A. I do not.

22 Q. Have you ever given deposition
23 testimony before today?

24 A. Yes.

25 Q. How many times have you given

1 deposition testimony?

2 A. Maybe five or six.

3 Q. And what are the contexts in which
4 you have been asked to give deposition
5 testimony, prior to today?

6 A. All of them -- all of them have
7 part -- been due to my private forensic
8 psychiatry practice, and they have been in
9 legal cases that I have been -- in that case,
10 all of them except for one, I was an expert
11 witness.

12 One of them I was a fact witness,
13 but it was because I had been an expert witness
14 for -- they never let me finish the review, but
15 for a capital murder defense, and basically I
16 was a fact witness for a new set of attorneys
17 who were making the argument that the first set
18 of attorneys did not do a good job defending
19 the person against the capital crime.

20 Q. Understood. In that instance, you
21 ended up not testifying, did I --

22 A. I was a fact -- in that case, I was
23 a fact witness, because I actually had never
24 finished my interview, let alone the paper
25 review, to give an opinion.

1 They wanted to know that fact, "Oh,
2 so they didn't even let you finish." That was
3 germane to their case against the lack of
4 defense by the first set of attorneys.

5 Q. Go it. You also said you have been
6 retained as an expert witness in matters, and
7 that is what resulted in your deposition?

8 A. Correct.

9 Q. And that's happened, did you say,
10 about four or five times?

11 A. Yeah. Maybe -- it's probably four,
12 it may be five times ever.

13 Q. Have you been retained by
14 plaintiffs lawyers, defense lawyers, or both --

15 A. Both.

16 Q. -- in your capacity as an expert
17 witness?

18 A. Both.

19 Q. When was the last time that you did
20 deposition testimony?

21 A. I believe earlier this year.

22 Q. As an expert?

23 A. Yes.

24 Q. What did the case involve?

25 A. Let me think about which one that

1 was. I believe that was a police case, so I
2 train the crisis intervention team officers in
3 Summit County. There aren't a lot of
4 psychiatrists in the country that do that.

5 So I am sometimes asked to look at
6 a case of a bad outcome with a police officer
7 or a sheriff's deputy. So this was a similar
8 kind of situation, where I was asked, and it's
9 not settled yet, so I probably can't officially
10 give you all the details, but basically they
11 asked my opinion about CIT training, could it
12 have prevented the bad outcome, that kind of
13 information.

14 Q. And were you a retained expert in
15 that case?

16 A. Yes.

17 Q. Who retained you?

18 A. In that case, it was the plaintiff.

19 Q. Do you get paid by the hour, when
20 you do that work?

21 A. Yes, I do.

22 Q. How much do you charge?

23 A. \$400.

24 Q. Now, we have your CV here, and I'm
25 going to mark that as Exhibit 1, for purposes

1 of your deposition.

2 - - - - -

3 (Thereupon, Deposition Exhibit 1,
4 Curriculum Vitae of Douglas A.
5 Smith, M.D., Beginning with Bates
6 Label SUMMIT 925093, was marked for
7 purposes of identification.)

8 - - - - -

9 Q. Dr. Smith, is this a copy of your
10 curriculum vitae?

11 A. Yes, it is.

12 Q. And you will see, by the numbers
13 down there in the bottom right-hand corner of
14 the document, that this is something that was
15 produced to us by lawyers for Summit County.

16 A. Uh-huh.

17 Q. Is this the most current version of
18 your CV?

19 A. Yes, it is.

20 Q. If you would turn to the second to
21 the last page. In the bottom right-hand
22 corner, it's the page number that ends in 98 --

23 A. Yes.

24 Q. -- do you see that?

25 A. Uh-huh.

1 Q. You make reference to some
2 presentations that you have given in your
3 professional capacity, correct?

4 A. Correct.

5 Q. And you say you have made over 70
6 presentations, yes?

7 A. Yes.

8 Q. And you have made those
9 presentations to various audiences on various
10 topics --

11 A. Yes.

12 Q. -- right?

13 These are topics, presumably, on
14 which you have some level of training and
15 expertise that you are informing others about?

16 A. Yes. Correct.

17 Q. It looks like most of these, not
18 surprisingly, relate to your work as a
19 psychiatrist?

20 A. Yes.

21 Q. At the bottom of the list, the next
22 to the last item that you list is Basics of
23 Court Testimony --

24 A. Yes.

25 Q. -- do you see that one?

1 A. Uh-huh.

2 Q. Can you tell us more about that?

3 A. Sure. So for many -- you can see
4 from the CV, for many years I worked at the
5 state psychiatric hospital, most of those years
6 as the medical director.

7 Many times our psychiatrists have
8 to testify in probate court for civil
9 commitment hearings. So I would train the
10 psychiatrists on, kind of, how to do that, what
11 to say, how to answer questions, that kind of
12 thing.

13 Q. Can you give us some examples of
14 the kinds of things that --

15 A. Sure. Well, I would --

16 THE NOTARY: Wait a minute. You've
17 got to let him finish the question before you
18 start please.

19 "Can you give us some examples of the
20 kinds" --

21 Q. -- the kinds of advise that you
22 would be giving to your audience, in that type
23 of presentation?

24 MR. KEARSE: Object to form.

25 A. So basically, I would give them a

1 little bit a background. I would talk about
2 the underpinning of civil commitment, Addington
3 versus Texas, Supreme Court case, and so forth,
4 so they had some understanding of what was
5 going on, and then basic talk about just say
6 the facts and make sure you have got the
7 records with you, and that kind of thing.

8 Q. You said you would kind of give
9 them some advice about how to answer
10 questions --

11 MS. KEARSE: Object to form.

12 Q. -- what did you mean by that?

13 A. Just what -- just that they need to
14 talk about the actual facts of the case so they
15 would -- we have a thing called a pink slip in
16 Ohio. I would make sure they read the pink
17 slip, so they give the actual information about
18 why the person first came to the hospital.

19 So basically just -- many of them
20 get nervous. It's really more about helping
21 them not be nervous, when they are testifying,
22 not about always say this or that. It's not
23 that kind of detail.

24 Q. Got it.

25 A. That's why it's basics.

1 Q. And have you testified in court
2 before?

3 A. Yes.

4 Q. How many times have you done that?

5 A. Well, civil commitment, many times.
6 In my private forensic world, three or four.
7 Most of the cases settle long before deposition
8 or even trial.

9 Q. When was the last time you
10 testified in a court proceeding?

11 A. It would have been also earlier
12 this year, in Georgia.

13 Q. In Georgia?

14 A. Uh-huh.

15 Q. And that's the case where you were
16 retained by plaintiff's counsel as an expert?

17 A. Yes. In that -- yes. In that --
18 so it was actually the general capital defense
19 group for Georgia itself defending a person
20 against a capital murder of a police officer,
21 and in that case, my testimony actually really
22 only was about CIT. I didn't actually talk
23 about the defendant at all, because I never got
24 to evaluate him.

25 Q. Got it. Let's turn to the front of

1 your CV, and if we get through your education
2 and work history, just for a few minutes --

3 A. Sure.

4 Q. -- that might be helpful.

5 A. Uh-huh.

6 Q. I'm just going to help the court
7 reporter here, and I should have said this at
8 the beginning. As you notice and you know from
9 your prior experience, the court reporter is
10 here typing up everything each of us says.

11 A. Yes.

12 Q. And it's hard for her to do that if
13 one of us is talking while the other is still
14 finishing a thought. I sometimes make that
15 mistake, you will probably do it, and we will
16 just do our very best to wait until one person
17 is done before the other starts talking.

18 MR. KEARSE: I may have an
19 objection once in a while as well too, but you
20 will be able to answer, unless I instruct you
21 not to, but sometimes it may be a three way, at
22 times.

23 MR. BOEHM: I certainly did not
24 mean to cut you out of that, Anne, in any way.

25 Q. Okay. So you went to the

1 University of Maryland at College Park,
2 correct?

3 A. For undergraduate, yes.

4 Q. For undergraduate. And for medical
5 school?

6 A. Actually the medical school was in
7 Baltimore. So they are, I don't know, 40 miles
8 apart or something.

9 Q. And you said you are from the
10 DC/Maryland area --

11 A. Yes.

12 Q. -- correct?

13 A. That's correct.

14 Q. That's where you grew up?

15 A. Yes.

16 Q. You majored in pre-medicine and
17 psychology, correct?

18 A. Correct.

19 Q. Why did you select that major?

20 A. Actually, I started, -- I thought
21 medical school early on, but I started as a
22 chemistry major, until I took an intro
23 psychology class and it -- I don't know, I
24 really liked the content, and that changed the
25 whole path that I took.

1 Q. Did you know when you entered
2 medical school that you wanted to go into
3 psychiatry?

4 A. I did, but I was actually open to
5 other -- liking other things, and I did like
6 other things, but in the end, psychiatry was
7 the winner.

8 Q. And that's what you did your
9 residency and fellowship in, right?

10 A. A residency in psychiatry. I did a
11 forensic fellowship specifically about both
12 civil and criminal evaluations, testimony, and
13 so forth.

14 Q. And you're board certified in
15 psychiatry and in forensic psychiatry, correct?

16 A. Correct.

17 Q. What does it mean, that you are
18 board certified in those areas?

19 A. It means that you -- it's not
20 required, but some of us choose to do it. We
21 do some extra -- often extra education, like
22 the forensic fellowship, and then in
23 psychiatry, when I did it, you had to do a
24 written exam, a national examination, pass that
25 examination, then you had to actually do an

1 oral examination in front of several other
2 psychiatrists of a -- a randomly assigned
3 patient at a randomly assigned site. I was in
4 Chicago for that.

5 So you have to make it through
6 that. That gets you board certified in
7 psychiatry. Forensic psychiatry is an
8 additional test, national test, all put on by
9 the American Board of Psychiatry and Neurology.

10 Q. What is forensic psychiatry?

11 A. Basically any intersection between
12 psychiatry and the law, although forensic
13 actually means public forum, so it really, to
14 me, includes teaching, educating the public and
15 others.

16 Q. Why did you choose to specialize in
17 forensic psychology -- I'm sorry, forensic
18 psychiatry?

19 A. Psychiatry. During medical school
20 I did a rotation at -- I think it's -- was the
21 first, actually, court psychiatric clinic in
22 the country, which happened to be in Baltimore,
23 Maryland.

24 The grandfather of forensic
25 psychiatry, Jonas Rappaport, ran the court, and

1 actually he was the one who started the
2 American Academy of Psychiatry and the Law.
3 That's why I refer to him as the grandfather of
4 forensic psychiatry.

5 I got to watch evaluations and --
6 as well as actually tapes of -- when there were
7 no evaluations, tapes of the Jeffrey Dahmer
8 trial and was -- really enjoyed the interaction
9 between them, all the legal issues, as well as
10 the psychiatric issues.

11 Q. Did you have some professional
12 objective in mind, when you decided to
13 specialize in forensic psychiatry?

14 In other words, did you have some
15 particular type of work you hoped to do with
16 that accreditation?

17 A. No. I don't think I thought about
18 that far in advance. I was fascinated by the
19 topic. I was still, kind of, in the mindset of
20 getting educated, so I, thankfully, got the
21 fellowship. There are very few of them in the
22 country.

23 I did the fellowship, which was
24 really a Johns Hopkins/Maryland combination,
25 and after that, I think it has helped me in

1 political work as well as in, obviously, some
2 occasional forensic work.

3 Q. What percentage of your work, over
4 the course of your career as a psychiatrist,
5 has been in a clinical setting?

6 A. All of it.

7 Q. All of it.

8 Would you characterize the work
9 that you do for the Summit County ADM Board as
10 clinical work?

11 A. Almost all of it.

12 Q. You are licensed to practice
13 medicine in the State of Ohio, correct?

14 A. Correct.

15 Q. Have you ever been licensed to
16 practice medicine in any state other than Ohio?

17 A. Maryland, when I was there, and
18 officially made it -- I had to do some
19 paperwork to make it inactive, but I could, if
20 I moved back, I could reactive it.

21 Q. It is inactive now, but --

22 A. Correct.

23 Q. -- you have some kind of status
24 there; is that fair?

25 A. That's fair.

1 Q. You also have the letters DFAPA
2 next to your name. Can you tell us what that
3 means?

4 A. Sure. So that's a Distinguished
5 Fellow of the American Psychiatric Association.
6 That means that I have done a fair amount of
7 service work on behalf of the -- mostly the
8 Ohio Psychiatric Physicians Association, OPPIA,
9 advocacy and chairing committees and things of
10 that nature, and if you do enough of that over
11 the course of time, you're able to get some
12 letters of recommendation from colleagues and
13 then apply for that.

14 Q. Okay. Are you licensed to
15 prescribe medications to patients?

16 A. Yes.

17 Q. How regularly -- how regularly do
18 you do that?

19 A. I have a small private practice,
20 half a day a week, where I actually treat
21 patients directly.

22 Q. Do they come to you in a private
23 office?

24 A. Yes.

25 Q. Is that like a therapy setting?

1 A. Well, I -- there is a psychologist
2 who created a large practice around Worker's
3 Compensation cases, and so he -- I don't work
4 for him, but the practice has a lot of offices
5 around the state, and they were looking for
6 psychiatrists. So I go to one of those offices
7 three afternoons a month and one of the other
8 offices the other afternoon a month, so
9 basically once a week.

10 Q. And are all of these cases Worker's
11 Comp related cases?

12 A. Everyone of them.

13 Q. So tell us more about what you do
14 in relation to what the patients are needing?

15 MR. KEARSE: Object to form.

16 A. So it's direct patient care. So my
17 official role is managing their medications
18 safely. Most of the patients have an allowed
19 condition, which is the wording they use when
20 they have vetted what there illness is; if it's
21 in the depressive disorder or anxiety disorder
22 range or overlap, occasionally something more
23 severe like schizophrenia, but most of them in
24 that range are in that range, plus PTSD, I do
25 treat some correction officers and other

1 officers that have work injuries that end up on
2 that system.

3 Q. Does any of your work involve
4 helping a patient make or sustain a claim for
5 Workers' Compensation?

6 A. None of mine does, no. There
7 are -- I think the practice has a couple of
8 psychologists who will do reports to either
9 allow -- add an allowed condition or argue to
10 allow a condition, but all of my stuff is
11 direct care, and that's it.

12 Q. Are you compensated by the practice
13 itself, or how do you get compensated for that
14 work?

15 A. So I -- the practice has a separate
16 billing company. So I submit my notes to the
17 billing company, they send them out, the checks
18 all come to me, then I pay an overhead fee to
19 the billing company, basically, each month.

20 Q. On the second page of your CV,
21 there is a reference to Private Practice in
22 Forensic Psychiatry.

23 A. Yes.

24 Q. Is that the category that we are
25 talking about now?

1 A. It would be the one above that,
2 Private Practice in Psychiatry.

3 Q. I see. And is this something that
4 you -- is this a business that you own?

5 A. Yes. I didn't incorporate it or
6 anything. It's just Doug Smith M.D.

7 Q. You don't have any partners working
8 with you in that --

9 A. No, or staff.

10 Q. And the private practice in
11 forensic psychiatry that I first looked at,
12 that has to do with your work as an expert
13 consultant; do I understand that correctly?

14 A. That's correct.

15 Q. Does it have to do with any work
16 outside of your work as a retained expert in
17 litigation?

18 A. No.

19 Q. What medication or medications do
20 you most commonly prescribe to patients in your
21 practice?

22 A. Sure. It would be -- it wouldn't
23 be exclusively. It would be antidepressants,
24 occasionally antianxiety medications,
25 occasionally medications to treat insomnia.

1 That's it.

2 Q. Have you ever prescribed any
3 controlled substance?

4 A. Benzodiazepines, like Valium,
5 Ativan, yes, that would be -- and I have not
6 prescribed stimulants, I have not prescribed
7 opiates, I have not -- that's it.

8 Q. All right. If we turn over to the
9 following pages of your CV, we see a little bit
10 more about your work history, right?

11 A. Yes.

12 Q. And if you start at the bottom,
13 because it looks like they are kind of in
14 reverse chronological order here, you started
15 with an entity called Northcoast Behavioral
16 Healthcare, correct?

17 A. Correct.

18 Q. Does that mean that was the first
19 job you took when you were completed with --
20 when you completed your fellowship?

21 A. That's correct.

22 Q. What is Northcoast Behavioral
23 Healthcare?

24 A. So the state psychiatric hospitals,
25 which are probably -- were 60 percent then,

1 about 70 percent forensic now, my forensic
2 interest, I sought work in a state psychiatric
3 hospital, for that interest.

4 So this was a campus in Toledo.
5 Northcoast was three of the state psychiatric
6 hospitals in Ohio, and they, because of stigma
7 and so forth, the whole system got rid of the
8 word "psychiatric" and so forth and the names,
9 and in this case we were Northcoast Behavioral
10 Healthcare.

11 Q. Were you working with patients who
12 were -- who were living at the hospital, or
13 were these people who could come and visit you
14 and then go back home?

15 A. In Toledo, it was specifically
16 people who were living in the hospital.

17 Q. And what kind of work did you do
18 there at Northcoast?

19 A. Mostly direct care of patients on
20 two -- we had four units. Two of the units
21 were forensic. I did also some clinical
22 administrative work, because there were no
23 other forensic psychiatrists who actually had
24 the training. So I revamped the system and set
25 it up so people could actually get out of the

1 hospital eventually and help the process.

2 Q. How did forensic psychiatry come
3 into play in the context of treating
4 psychiatric patients in a psychiatric hospital?

5 A. So in the state system, the
6 forensic mostly refers to people who have been
7 found not guilty by reason of insanity, using
8 an Ohio term, and/or not competent or possibly
9 not competent to stand trial.

10 So we would treat individuals to
11 help treat their illness, we would work with
12 the courts a lot around the NGRI population,
13 and eventually many of them would be released
14 to the community on an out-patient program
15 called conditional release, which is not what I
16 was doing. I was doing the inpatient.

17 The competency to stand trial, you
18 know better than I the laws, but we have a
19 right to a fair trial, and it's not fair if you
20 don't understand what's going on or can't work
21 with your attorney. So we would treat
22 individuals to help restore their capacity to
23 have a fair trial, and then they might go back
24 to jail and then to trial.

25 Q. Would you sometimes be called upon

1 to render an opinion as to the competency of
2 somebody who might need to stand trial?

3 A. Yes.

4 Q. Was that a routine part of your
5 job?

6 A. Yeah. That's what we were -- we
7 had to do that, as well as occasionally the
8 opinion about sanity legally.

9 Q. What do you mean, "Occasionally the
10 opinion about"? You would offer an opinion in
11 a court of law as to whether or not a criminal
12 defendant was sane?

13 A. Using the legal term, yes, we
14 would, yes.

15 Q. Would you be a witness for the
16 state, in that kind of proceeding?

17 A. That's correct, yeah. We would be
18 the neutral, working directly for the judge, as
19 opposed to either plaintiff or prosecution.

20 Q. During your time at Northcoast --

21 A. Or defendant. Sorry.

22 Q. I'm sorry?

23 A. I meant defendant or prosecution,
24 but, yeah.

25 Q. Okay. During your time at

1 Northcoast, did you have any oversight or
2 direct responsibility related to the use of
3 opioid medicines?

4 A. I would say yes to that. So if you
5 look further up the CV, I eventually became the
6 medical director for all.

7 Three of our psychiatric hospitals,
8 Toledo, downtown Cleveland, and then
9 Northfield, which is the main one at this point
10 for Northcoast, and three outpatient programs.

11 So we did have a group of
12 pharmacists, and ultimately the head pharmacist
13 did report to me. So I would have had
14 oversight. Not that we prescribed a lot of
15 opioids there, but yes, I would have had
16 oversight of that, yes.

17 Q. Did you prescribe some opiates to
18 patients in these psychiatric hospitals?

19 A. I didn't directly, because by then
20 I was in that medical director role, but it did
21 happen.

22 We had officially 3.7, but 4
23 internal medicine -- sorry -- three internal
24 medicine, one family medicine person, they
25 would do that prescribing.

1 Q. What were the occasions when
2 opiates might be prescribed to a psychiatric
3 patient, under your direction as the medical
4 director for these psychiatric hospitals?

5 MR. KEARSE: Object to form.

6 A. Well, patients would come, and we
7 would do a process called medical clearance, to
8 make sure they didn't have a serious physical,
9 medical concern that might compromise their
10 health, because we didn't have cardiac
11 telemetry to monitor their hearts and all that.
12 It was all very -- we didn't do IV fluids.

13 So we needed, basically, physically
14 healthy people, but some of them would come in
15 already prescribed opiates for pain. We were
16 not the place that started them, but if they
17 came in with a known back injury, and they were
18 going to be in the hospital for days or weeks,
19 forensically, months perhaps, then our doctors
20 would often -- we would send them out to
21 specialty clinics, usually at MetroHealth if
22 Cleveland, or Toledo would be University of
23 Toledo, and then if we got recommendations that
24 they needed ongoing medications, our primary
25 care doctors would continue those.

1 Q. Have you ever prescribed an opiate,
2 over the course of your career?

3 A. I don't recall ever doing it. If
4 it happened, it might have been in that Toledo
5 hospital, years ago, direct -- directly caring
6 for patients.

7 Q. When did you first learn about the
8 class of medications sometimes referred to as
9 opioids?

10 A. Medical school.

11 Q. What did you learn about opioids in
12 medical school?

13 A. Medical school, for me, would have
14 been -- I finished in 1993, so it was a while
15 ago, but basically we learned all the classes
16 of medications, we had psychopharmacology
17 classes and, quite frankly, most of what I
18 learned was they were for pain, they were
19 really mostly for extreme pain, cancer pain,
20 end-of-life pain, and that we should be careful
21 with them, because people could become
22 addicted.

23 Q. So you learned in medical school
24 that opioids can have addictive properties?

25 A. Yes.

1 Q. Is that something that you think is
2 commonly taught in medical schools?

3 MR. KEARSE: Object to form.

4 A. I don't teach that in medical
5 schools. I'm assuming they haven't stopped
6 teaching it though.

7 Q. Did Northcoast Behavioral
8 Healthcare, during the time that you had
9 oversight as the medical director, have any
10 prescribing guidelines in place for the
11 prescribing of opioid medications?

12 A. I don't believe so.

13 Q. Is it fair to say that the
14 prescribing of opioid medications was left to
15 the discretion of the primary care physicians
16 who were interfacing directly with patients?

17 MR. KEARSE: Object to form.

18 A. I would say mostly. And the reason
19 is that we did regular reviews of what was
20 being prescribed of all types of medications
21 across our system, and if we saw anything that
22 appeared to be overprescribing or needless
23 prescriptions, then we would have discussions
24 about that.

25 Q. Did that ever happen, in the

1 context of your physicians prescribing opioid
2 medications?

3 A. One time. We -- my head pharmacist
4 came to me, and I couldn't tell you the year,
5 but 2006 or something, came to me and
6 said -- let me step back.

7 I had physicians on call admitting
8 patients telling me, "I admitted another person
9 from Lake County," a county up north here, and
10 it was rare that we had anybody on opiates, but
11 what happened was they had several doctors tell
12 me, in the course of a short time, all these
13 patients were from Lake County.

14 So I asked that pharmacist to run a
15 report and tell me, well, what percentage of
16 the opiates we prescribe are coming from Lake
17 County. The answer was 78 percent, and they
18 were like five of our 260 beds, patient beds.

19 Anyway, so that's the one time I
20 was aware, but it really was not us prescribing
21 them, it was people coming in on them.

22 Q. So in this instance when your head
23 pharmacist came to you and reported that he
24 was -- he or she was seeing patients from Lake
25 County being prescribed opioids, did you

1 investigate?

2 A. I did.

3 Q. What did you conclude, based on
4 looking into that?

5 A. I took it to their director of
6 their ADM Board, Linda Frazier, who is still
7 there, actually, in the role that Jerry Craig
8 is on our ADM Board. She was able to run not
9 names, because of HIPPA, but zip codes of who
10 was coming to the pain clinics in Painesville,
11 and people were driving from as far as Florida
12 to come to those pain clinics.

13 Q. Do you know if any action was ever
14 taken by the Ohio Medical Board or any other
15 entity in terms of prescriptions that were
16 being made by pain clinics in Lake County?

17 A. Yes. Eventually they passed -- I
18 don't remember the bill, but they called it the
19 pill mill bill in Ohio, to go after the few,
20 but there were some unscrupulous physicians who
21 were just handing out opiates improperly and
22 probably illegally, and they did shut them down
23 eventually.

24 Q. Are those sometimes referred to as
25 pill mills?

1 A. Yes.

2 Q. Did you ever see problems with pill
3 mills in Summit County? Setting aside what you
4 saw in Lake County, did you ever see an issue
5 with so-called pill mills in Summit County?

6 A. I didn't see the issue, but we
7 saw -- I remember one of our staff bringing us
8 a photo of a hand-painted sign from the side of
9 the road, you know, need opiates, call this
10 number, kind of thing, but as far as actually
11 seeing the pill mill, I did not.

12 Q. Well, I don't mean necessarily
13 seeing it with your own eyes. My question
14 really to you, Dr. Smith, is whether or not you
15 were aware of specific instances of pill mills
16 in Summit County?

17 A. I wasn't fully aware. Our
18 addiction specialist told me he wondered about
19 a particular practice in Summit County, whether
20 they were giving -- they were overprescribing
21 opiates.

22 I don't believe it got investigated
23 for that at any point, because the main
24 physician there got in separate legal trouble
25 for some other problem. I don't remember

1 whether it was fraud or something, but it was
2 not about opiates, but eventually got in
3 trouble for -- and then that clinic vanished.

4 Q. Okay. So in your work at
5 Northcoast, and up to today, you can't identify
6 any specific instance in Summit County where
7 there was a practice that you would
8 characterize as a pill mill?

9 A. Well, the definition was they had
10 to -- 50 percent or more of their patients were
11 getting opiates, was, I think, the way the law
12 characterized it, and I was not aware, other
13 than, again, a pain clinic, which is the one
14 where this doctor was at, which may or may not
15 have been legitimate, because I'm not
16 the -- ADM doesn't investigate those things.
17 That's the only one I was even lightly aware
18 of.

19 Q. So the answer is you're not aware
20 of any specific instance where you determined,
21 within Summit County, that a particular
22 practice was a so-called pill mill; is that --

23 A. Correct.

24 Q. -- correct?

25 Are you aware of physicians at

1 Northcoast Behavioral Healthcare ever making
2 illegitimate prescriptions of opioids to
3 patients?

4 A. Never.

5 Q. Are you aware of any hospitals
6 within Summit County who made illegitimate
7 prescriptions of opioids to patients?

8 A. No.

9 Q. Are you aware of any particular
10 medical practices, that you can identify for us
11 within Summit County, who made illegitimate
12 prescriptions of opioids to patients?

13 A. No.

14 Q. In May 2012, you became the chief
15 clinical officer for the Summit County ADM
16 Board, correct?

17 A. Correct.

18 Q. And then I see in parentheses, it
19 also says medical director. Is that -- can you
20 explain the difference, if there is one,
21 between chief clinical officer and the medical
22 director?

23 A. Sure. There is no difference. The
24 law defines the chief clinical officer, if you
25 look at the Ohio Revised Code, says the medical

1 director of.

2 I did that because, until coming to
3 Ohio, I never heard the phrase "chief clinical
4 officer," and so others looking at my CV might
5 not even know what that was, so on the CV I put
6 both names.

7 Q. Why did you decide to join the
8 Summit County ADM Board in May 2012?

9 A. So from my vantage point at the
10 state hospital, all three sites, we saw the ADM
11 Boards from the Indiana border to the
12 Pennsylvania border, and during my many years
13 there, Summit County was always the best.

14 They always had the best array of
15 services, seemed to be the most collaborative.
16 Again, I don't know about the southern part of
17 the state, but northern part of the state, they
18 were the best.

19 So Dr. Munetz, who was in my role
20 prior to me, approached me. He was in the
21 process of moving fully into NEOMED, the
22 medical school, as their chair of psychiatry,
23 and I thought about it a fair amount and
24 decided that that was a pretty good
25 opportunity, just a change of -- change of

1 pace, but to come to the best board I had seen
2 for over a decade, and that was the reason I
3 entertained that.

4 Q. When you described the Summit
5 County ADM as the best board you've seen, can
6 you just tell us a little bit more about why
7 you think that's true?

8 A. Certainly. So most responsive to
9 new areas that need attention for treatment;
10 most responsive to filling gaps in the
11 care -- the continuum of care; leaders, as we
12 still are, in a number of areas, even
13 nationally, like crisis intervention team,
14 training of police officers, assisting in
15 outpatient treatment.

16 So it was an opportunity to, you
17 know, to work with a group that already had a
18 good track record, and then tried to help
19 further that.

20 Q. Were there particular issues that
21 you were interested in that you thought this
22 new position would give you an opportunity to
23 address, when you made the decision to go from
24 Northcoast over to the Summit County ADM Board?

25 A. Yes. Forensically, the -- our

1 board was and is known in our area, actually,
2 here in Summit County, for working hard on jail
3 diversion, so forensic-type topics.

4 So we really try hard to have a
5 system where individuals do not end up in jail
6 because of mental illness, disorderly
7 conduct -- I mean, we really try hard to have
8 them go get treatment through our system, and
9 so that, for me, was a big draw, to be able to
10 do that. That was not something I could deal
11 with from the state hospital vantage point.

12 So to do that in a reasonable-sized
13 county, with a good group of people who were
14 already thinking in the same way, was one of
15 the reasons I thought it was a good place to
16 work.

17 Q. Okay. Anything else that stands
18 out in your mind as something you were very
19 interested in and a reason why you wanted to
20 join the Summit County ADM Board?

21 MR. KEARSE: Object to the form.

22 A. I think I gave you the big ones.

23 - - - - -

24 (Thereupon, Deposition Exhibit 2,
25 2014 Annual Clinical Report for ADM

1 Funded Programs and Services,
2 Beginning with Bates Label SUMMIT
3 833675, was marked for purposes of
4 identification.)

5 - - - - -

6 Q. Now, I have set a document in front
7 of you that I've marked as Exhibit 2 for
8 purposes of this deposition, and this is a 2014
9 annual clinical report that has to do with the
10 Summit County ADM Board; do you see this
11 document?

12 A. Yes, I do.

13 Q. Is this something that you are
14 familiar with?

15 A. Yeah. I haven't seen it in a few
16 years, but, yes, I have certainly seen it.

17 Q. And it says at the beginning that
18 it has an executive summary that describes the
19 ADM Board as a special purpose government
20 agency; do you see that?

21 A. Yes.

22 Q. Do you know what that means?

23 A. Yes. So you can see Ohio Revised
24 Code is listed here.

25 The Ohio Revised Code section 340

1 defines the legal entities known as ADM Boards.
2 Some places call themselves recovery service
3 boards or ADAMHS boards, but same idea.

4 And so it sets is apart as a
5 separate special government agency to deal
6 with -- and you can see it here -- the
7 planning, funding, monitoring and evaluating
8 treatment of prevention services for all the
9 county residents for alcohol, drug addiction,
10 and mental health services.

11 Q. What does it mean that the ADM
12 Board is a special purpose government agency?

13 A. So we are very focused on that
14 relatively -- it cuts across a lot of people,
15 it's a broad thing, but it is a very focused
16 mission purpose, compared to other government
17 agencies.

18 Q. Are there other entities in Summit
19 County government that are focused on drug
20 abuse, addiction, addiction treatment and the
21 issues that the ADM Board are focused on?

22 A. Government agencies?

23 Q. Yes.

24 A. So the -- originally, no. I think
25 because of the opioid epidemic, the Summit

1 County Health Department, because it became a
2 public health issue, has also been a partner
3 with us and others on this, yes.

4 Q. When would you say that the public
5 health department for Summit County became, as
6 you put it, a partner to the ADM Board, in
7 terms of addressing opioid abuse?

8 MR. KEARSE: Object to form. I
9 think he said "epidemic," but go ahead.
10 Mischaracterizes his testimony.

11 A. Late 2013, early 2014.

12 Q. What happened at that time?

13 A. Two things. One, we moved our
14 prior location to the same building as public
15 health, so we were co-located, which is very
16 good for integrated medical care in the first
17 place; and then during 2013 is when we first
18 were becoming aware of the numbers of people
19 dying from opioid overdoses, and we started to
20 work on pulling together an opiate task force.

21 Q. Did you say 2013 was the first time
22 you learned that people were dying from opioid
23 abuse?

24 A. It's the first time that -- it's
25 when -- not the first time. It's when the

1 people around the county started talking about,
2 wow, we need to do something about this.

3 Q. So your testimony today is that
4 2013 is the first time people in the county
5 started to talk about the impact of opioid
6 abuse --

7 MS. KEARSE: Object to form.

8 Q. -- within Summit County; is that
9 your testimony?

10 MR. KEARSE: Object to form. I'm
11 sorry. I apologize. I thought he was finished
12 with his question.

13 Q. Go ahead.

14 A. So 2013 is the first time that I
15 became aware that people were discussing, wow,
16 we have a real issue here.

17 Q. Okay. We are going to look at some
18 documents from earlier than that. Would that
19 surprise you?

20 MR. KEARSE: Object to form.

21 A. No. I mean, once we learned about
22 it, we ran data for 2012, for example, so we
23 had that information. Again, I didn't get
24 there until May 1 of 2012, so relatively early
25 in my time, I learned that there was an issue.

1 Q. Okay. So you are saying, today
2 your testimony is, that it wasn't until you
3 arrived at the ADM Board in May of 2012 that
4 you recognized that there was an issue in
5 Summit County in connection --

6 MS. KEARSE: Objection. Form and
7 argumentative.

8 MR. BOEHM: I'm sorry. I'm not
9 even done yet. Let me finish my question.

10 MR. KEARSE: Well, you are
11 badgering the witness. You are being
12 argumentative.

13 So if you have a question or a
14 document you can show him --

15 MR. BOEHM: If you want to make an
16 objection, Anne, you wait until I'm done with
17 my question, and then make your objection, and
18 it should be to form. I don't need you
19 stopping me in the middle of my question to
20 make an argument. I don't want that to happen
21 today, and that's inappropriate. You shouldn't
22 be doing it. Please don't do that.

23 If you want to object when I'm
24 done, you have every right to do that, but not
25 in the middle of my question, not appropriate,

1 please don't do.

2 MR. KEARSE: I'm going to ask you
3 not to argue with the witness, and if you have
4 a question, ask the question, if you have a
5 document, show him a document. We are not here
6 to argue or be rude to the witness.

7 MR. BOEHM: I'm not being rude to
8 the witness, but you are being rude to me.
9 Let's not waste time, okay?

10 MR. KEARSE: I'm not the one
11 wasting time.

12 Q. Dr. Smith, is it your testimony
13 here today that you did not know that there was
14 an opioid abuse problem happening in Summit
15 County, until you arrived at the ADM Board in
16 May of 2012?

17 MR. KEARSE: Object to form.

18 A. I don't know that I can answer the
19 question using the phrase "opiate abuse," but I
20 was not aware that there was a great increase
21 in overdose deaths until 2013, that's correct.

22 Q. Until 2013?

23 A. Correct.

24 Q. And what is your understanding as
25 to when you think that increase in deaths took

1 place, in relation to opioid abuse?

2 MR. KEARSE: Object to form.

3 A. Well, after 2013, as we saw this,
4 we started looking at data. The department of
5 health created a graph that shows, actually, an
6 upward trend, starting in about 1999, all the
7 way -- well, at that time through 2012 was the
8 data they had, that's most of the graphs, but,
9 unfortunately, that graph kept going up after
10 that.

11 Q. Okay. And that's something you
12 didn't know about until 2013?

13 A. Correct.

14 Q. Okay. We are certainly going to
15 come back to that.

16 Just to stay with this document
17 here --

18 A. Sure.

19 Q. -- that's marked as Exhibit 2, the
20 executive summary, in describing the ADM Board,
21 refers to alcoholism, drug addiction and mental
22 illness; do you see that?

23 A. Yes.

24 Q. Is it fair to say that those are,
25 kind of, the three broad categories that define

1 the mission of the Summit County ADM Board?

2 A. Yes.

3 Q. The next sentence there says that
4 the board does not provided any direct service,
5 but contracts with local agencies to provide
6 services. What does that mean?

7 A. So we are a funding entity. We
8 bring in -- about 80 percent of our dollars
9 come from a local levy real estate tax, 10
10 percent federal, 10 percent state dollars, and
11 then we, as a team, about 20 of us, we then
12 fund partially or sometimes entirely about 25
13 agencies across the county who are focused on
14 either alcohol, drug addiction or mental health
15 services or both. Some do both.

16 Q. So the ADM Board itself doesn't
17 provide the services directly to individuals in
18 the county?

19 A. That's correct.

20 Q. So when you said that your work as
21 the medical director for the Summit County ADM
22 Board is a clinical position, tell us what you
23 mean by that, in light of the statement that
24 the ADM Board does not itself provide any
25 services directly to patients?

1 A. Sure. So the role for myself and
2 another handful of clinicians at the board, is
3 that we help the board determine where dollars
4 might be spent for -- to fill gaps and improve
5 patient care cross the system, and then we also
6 go out and evaluate, to make sure we are
7 getting good clinical outcomes from the money
8 that we are spending on that care.

9 We need to be able to share with
10 the public, it is their dollars after all, that
11 we are getting good bang for the buck --

12 Q. How do you --

13 A. -- clinically.

14 Q. I'm sorry.

15 How do you go about ensuring that
16 you are getting good bang for the buck from the
17 contractors who are actually rendering the
18 services that you are funding?

19 A. So again, our team does audits on a
20 regular basis, looking through the charts
21 clinically, as well as our fiscal side does
22 fiscal audits of all the claims made, all the
23 billings made, to make sure the patients are
24 getting the care they need.

25 Q. Are you involved in that auditing

1 process?

2 A. I review the -- some of the audits
3 after the fact. I'm not the one
4 usually -- I've been to some, but I'm not
5 usually the one sitting there going through the
6 charts.

7 Q. You go and visit the facilities
8 that are rendering the services?

9 A. Yes, regularly.

10 Q. And you survey the level of care
11 that's being provided?

12 A. Yeah. I look at the level of care,
13 and then if there are challenging individuals
14 in the system that are touching more than one
15 agency, I can call, which I do regularly,
16 what's called a case conference, and
17 everyone -- kind of like this, the room is
18 usually full, and we walk through the case and
19 figure out where can we give better services to
20 help that particular person.

21 Q. Has there ever been an occasion
22 where you felt that the services being provided
23 by the contractors but funded by the ADM Board
24 were subpar?

25 A. There are certainly cases where we

1 are not getting the outcomes that we would
2 like, and then we have meetings and discuss it
3 with -- they get better.

4 Q. How do you go about addressing
5 those types of problems?

6 A. A number of ways. I mean,
7 obviously, we hold the dollars on some of those
8 things, so we are able to say, well, we want to
9 do more with the funding in this area than that
10 area.

11 We have a process by which agencies
12 can request to add a service. We only really
13 will to do that if it is an evidence-based
14 practice, so there is research behind it that
15 says, if they do it this way, we will get these
16 outcomes, because sometimes outcomes take
17 years, so we're not going to -- it's not like
18 every six months we can say, hey, did you cure
19 X number of people? So we're looking out.

20 So more of the ways that we can
21 have checks and balances on it, and then help
22 them improve the service they are providing.

23 Q. I've marked this document as
24 Exhibit 3.

25 - - - - -

1 (Thereupon, Deposition Exhibit 3,
2 2018 Budget For the Summit County
3 ADM Board, Beginning with SUMMIT
4 897931, was marked for purposes of
5 identification.)

6 - - - - -

7 Q. And you will see that it is a 2018
8 budget for the Summit County ADM Board that was
9 presented to the board of directors on July 15,
10 2017; do you see that?

11 A. Yes, I do.

12 Q. I'll direct your attention to page
13 10 of this document, which looks to be an
14 organizational chart for the ADM Board.

15 A. Yes.

16 Q. You made reference to a board of
17 directors for the ADM Board, right?

18 A. Yes.

19 Q. And that's what we're seeing at the
20 very top of this chart?

21 A. That's correct.

22 Q. How many members of the board of
23 directors are there?

24 A. Fourteen.

25 Q. And how are they selected?

1 A. I believe that eight of them have
2 to be approved through the Ohio Department of
3 Mental Health and Addiction Services, and they
4 look for a range of individuals, including
5 people maybe with their own lived experience,
6 with no health or addiction, and the other six
7 are appointed here locally, and I believe they
8 have to be officially approved by the county
9 executive.

10 It gives us both the local and the
11 state picture, gives us the perspective of many
12 people in the community. We have got a couple
13 of attorneys. It gives us a broad look at
14 what's going on.

15 Q. Do you have any medical doctors on
16 the board of directors?

17 A. Yes, we do.

18 Q. Who do you have on the board of
19 directors who are --

20 A. I believe we have --

21 Q. I'm sorry. You got to wait until
22 I'm finished, and then you can start.

23 My question was --

24 MR. BOEHM: I think you got it.
25 Did you get my question?

1 Q. How many members of the Summit
2 County ADM board of directors are medical
3 doctors?

4 A. One.

5 Q. And who is that?

6 A. Dr. Todd Ivan.

7 Q. What kind of practice does Dr. Ivan
8 have?

9 A. He is a consult liaison
10 psychiatrist at Summa.

11 Q. Is it I-V-A-N?

12 A. Yes.

13 Q. What is Summa?

14 A. One of our two large healthcare
15 systems here. We have Summa, and then we have
16 Cleveland Clinic/Akron General.

17 Q. Are any ADM employees or staff also
18 members of the board of directors?

19 A. No. That wouldn't be allowed.

20 Q. What about Mr. Craig, is he a
21 member of the board of directors?

22 A. So, yeah. He would be -- he is,
23 but he reports to the board. So however that
24 works.

25 Q. He reports to the board, but my

1 question is, is he, in addition to being the
2 executive director for the ADM Board, is he
3 also a member of the board of directors?

4 A. I don't know if there are subtle
5 distinctions or not about that. I know that if
6 they go in executive session, he's in there
7 with the board of directors generally.

8 Q. Do you ever attend board of
9 director meetings?

10 A. Most of them, yes.

11 Q. How often do those occur?

12 A. Eleven times a year.

13 Q. Okay. So almost monthly?

14 A. Yes.

15 Q. There is one month when it doesn't
16 happen?

17 A. Yeah. Because they are at the end
18 of the month, the November one would conflict,
19 as it would next week, with Thanksgiving week.
20 So they have one in early December that covers
21 both November and December.

22 Q. And you said there is something
23 called an executive session?

24 A. Yes.

25 Q. And that's not open to the public?

1 A. Correct.

2 Q. Are there minutes kept of the
3 executive session?

4 A. I honestly don't know, because I
5 wouldn't see them, if they did.

6 Q. Are there minutes kept of the
7 public session of the board of director
8 meetings?

9 A. I believe, yes, for that.

10 Q. And do those get circulated to
11 members of the ADM Board?

12 A. Yes.

13 Q. Is that something that you see on a
14 regular basis?

15 A. Yes.

16 Q. Do those get emailed?

17 A. I'm sure they must.

18 Q. Is that how you receive --

19 A. We don't print very much stuff,
20 yes, so, yes.

21 Q. What do you understand the board of
22 directors' duties to involve?

23 A. They are there to ensure the
24 mission of the organization, to make sure the
25 money is being spent wisely, to -- so we use a

1 structure called policy governance, and under
2 that structure, they have certain duties, that
3 they then hold Jerry Craig accountable as the
4 director, and then ultimately, of course, he
5 holds the rest of us accountable to him.

6 Under policy governance, they have
7 a global ends, they call it, list of things
8 that we are -- Jerry is supposed to accomplish
9 with his staff, and they review those parts of
10 them each month, so they are all reviewed
11 annually.

12 Q. Did you ever receive any
13 instruction, in connection with the filing of
14 this lawsuit, to preserve materials that you
15 might have in your possession, whether it be
16 electronic materials on your computer or in
17 hard copy, to preserve those materials, to the
18 extent they relate to issues that are alleged
19 in the complaint?

20 A. Yes.

21 Q. Do you remember when you received
22 that?

23 A. I don't recall. I think it was,
24 again, maybe early 2018.

25 Q. Do you ever interact directly with

1 members of the board of directors, in terms of
2 them making a request to you for something?

3 A. There is a meeting called the
4 assurance committee.

5 Q. I'm sorry. Assurance?

6 A. Assurance, yes. So the assurance
7 committee will ask -- ask to talk about certain
8 data occurring in the county, most commonly
9 that's deaths by suicide. It might be other
10 things that have come to their attention, and
11 then generally, both Aimee Wade, you can see on
12 here, she's really my counterpart with the
13 clinical team, and I, we attend that meeting
14 and bring them data and have discussions.

15 Q. Why is it most commonly death by
16 suicide that the assurance committee is
17 interested in?

18 A. Important topic, we would like to
19 drive those down.

20 Q. Are there other examples that you
21 can recall in your time at the Summit County
22 ADM Board where the assurance committee has
23 come to you with a particular request on a
24 subject?

25 A. I mean, we review, sometimes, other

1 types of data in there. It depends on what --
2 often it's what they have heard in the board
3 meeting, they will then say, hey, we kind of
4 like to hear more about X.

5 It might be administrative
6 discharges from our residential treatment
7 program, for example. So we have people going
8 in there getting care for alcohol or drug
9 addiction, and then they don't finish their
10 stay, because maybe they were using substances,
11 maybe they were fighting with other people and
12 they get kicked out, basically. They want to
13 review that and make sure we are not,
14 basically, spending money for nothing. You
15 don't want to spend the money for somebody to
16 be there for 20 days and then throw it all away
17 because they -- so that kind of stuff we've
18 looked at.

19 Q. Are there any other examples that
20 you can think of where the assurance committee
21 has come to you requesting specific information
22 about a specific issue?

23 A. No. Those are the two main topics.

24 Q. Now, if you look to the far left of
25 this organizational chart, I think we see your

1 name, Doug Smith M.D., Chief Clinical Officer;
2 do you see that?

3 A. Yes.

4 Q. That's you, right?

5 A. That's me.

6 Q. And you have the names of three
7 individuals who appear to report to you; is
8 that right?

9 A. That's correct.

10 Q. Mr. Aaron Ellington,
11 Mr. Christopher Freeman-Clark, and Ms.
12 Christine Smalley, right?

13 A. That's who is listed, yes.

14 Q. Are those the individuals who
15 are -- -- all of those individuals still at the
16 ADM Board?

17 A. No, they are not.

18 Q. Who is not there anymore?

19 A. Christine Smalley is no longer. We
20 are in the process of filling that position.

21 Q. So that position is not filled
22 right now --

23 A. Correct.

24 Q. -- it's vacant.

25 What about the other two?

1 A. Both are there.

2 Q. What are the responsibilities of
3 Mr. Ellington and Mr. Freeman-Clark?

4 A. Okay. So actually Dr. Ellington --

5 Q. Oh, sorry about that.

6 A. -- he's a psychologist. We, Jerry
7 and I, and maybe others contributed, but we
8 decided that, in order to, again, better verify
9 that we are getting the best outcomes for the
10 money we spent, we decided to hire somebody who
11 could really be focused on evidence-based
12 practice, and we created a position, we went
13 looking, we found Dr. Ellington, he's
14 excellent.

15 So his role is to make sure that we
16 are asking the right questions when we are
17 looking at services our agency is providing,
18 and also then to vet requests from other
19 agencies, saying, "Hey, we would like to
20 add" -- recently we have done a big program on
21 cognitive behavioral therapy, and so his job is
22 to make sure we are structuring it right, that
23 we are doing it faithfully to the model that
24 was -- exactly the way the research was done.
25 So fidelity to the model is the phrase.

1 And then he follows that, and he
2 will visit them, he will make sure that things
3 are happening in the way they are supposed to.

4 Chris Freeman-Clark is our forensic
5 monitor and the title coordinator of forensic
6 services. What that means is that he's in the
7 court a lot. He is there to watch and make
8 sure things flow smoothly, and really to
9 educate the judges, who often don't get a lot
10 of education in mental health law, for the
11 individuals in Summit County on conditional
12 release, who have been found previously not
13 guilty by reason of insanity.

14 So he helps that and works closely
15 with community support services, which is the
16 agency that treats all those individuals.

17 Q. Are either of these individuals
18 particularly focused on the issue of opioid
19 abuse?

20 A. No.

21 Q. When you look over the
22 organizational chart overall, are there any
23 individuals that you see who are particularly
24 focused on the issue of opioid abuse?

25 A. Yes. Most squarely would be Kim

1 Patton, our addictions prevention and training
2 coordinator, and because Christine Smalley is
3 not with us right now, Dr. Ellington has at
4 least been attending our -- what used to be
5 called wait-list meeting, that is people
6 waiting to get into residential treatment
7 services.

8 I believe they just told me they
9 changed the name last week. I honestly don't
10 remember the name, but something like Access or
11 something, because it is not really a wait
12 list, because most people are not waiting there
13 in jail or something, and we can't exactly say
14 they are waiting, because they can't just come
15 in today, but it's an access issue.

16 Mostly through Kim Patton,
17 some would -- it's touched all of us in the
18 recent years. Beth Kuckuck, who does the
19 children program, certainly the opiate issue
20 has come up in the adolescent hospitalization.

21 And then Eric Hutzell is our main
22 data person, so he would see all the data,
23 creates the charts and graphs that we put out
24 at our quarterly opiate task meeting and so
25 forth. So he sees a lot of data on opiates, as

1 well as mental health and so forth.

2 Q. Anybody else on this list focused
3 on opioids?

4 A. Well, the entire fiscal side is
5 paying a lot of claims for people being treated
6 for opiate use disorder, and obviously then
7 Jerry Craig and the board of directors
8 certainly have been watching that carefully and
9 providing -- and Jerry particularly, providing
10 a lot of leadership for us and for the county
11 around -- and sometimes at state meetings, you
12 know, dealing with the sad deaths from the
13 opiates.

14 Q. Anybody else?

15 A. Well, I think I, sort of, covered
16 everybody.

17 Q. You said that those on the fiscal
18 side are, I think you said, paying a lot of
19 claims?

20 A. Yes, that's correct.

21 Q. What do you mean by that?

22 A. Well, so they are the ones -- so
23 the money, as I said, we are a funder, so a
24 good proportion of our staff are focused on
25 making sure claims get paid. So as agencies

1 bill for services that Medicaid and other
2 insurances don't pay for, then they are
3 processing those claims, and when we have our
4 meetings and talk about it, it's clear they
5 have been processing a lot of claims for opiate
6 use disorders.

7 Q. And do they calculate what the
8 costs are to the Summit County, related to the
9 issue of opioid abuse?

10 A. I'm sure they have.

11 Q. Do you know what those amounts are?

12 A. I do not.

13 Q. Who would we talk to at the ADM
14 Board to try and figure that out?

15 A. I'm sure Jerry Craig is aware;
16 otherwise, Jennifer Peveich is our director of
17 operation. She is also our chief financial
18 officer. So she is the expert on that.

19 Q. You made reference in one of your
20 earlier answers to a state entity, I think it
21 is O-M-A-S, did I get that right?

22 A. Yeah. It's the Ohio Department of
23 Mental Health and Addiction Services. So they
24 often say OHMAS.

25 Q. OHMAS. Ohio Department of Mental

1 Health and Addiction Services, right?

2 A. Correct.

3 Q. What is that?

4 A. So when I was working at the state
5 hospital, I think the entire time actually, we
6 had two separate departments. So these are
7 departments who have directors that report
8 directly to the governor.

9 So the Ohio Department of Mental
10 Health and the Ohio Department of Alcohol/Drug
11 Addiction Services, they merged probably July,
12 I believe, like somewhere around July 1, 2013.
13 Maybe it's a little off on the date. So they
14 merged into one department, so they could focus
15 on, kind of, everything about the brain and be
16 more efficient.

17 Q. Is it still called OHMAS?

18 A. Yes.

19 Q. Is there some relationship between
20 the Summit County ADM Board and the state
21 agency, the Ohio Department of Mental Health
22 and Addiction Services?

23 A. There is, in that we frequently
24 have discussions, we sit on committees that
25 they may run, and then about 10 percent, it's

1 increased as far as opiate money, I think,
2 because of the Cures Act and other things, but
3 then they receive moneys at the state level,
4 which they then parse out to the counties.

5 So they would also then send us
6 funding for that. They send us funding for --
7 to help fight deaths by suicide as well. And
8 so their role is pretty broad, and they -- so
9 then their -- I do talk pretty regularly with
10 the medical director -- well, I should say
11 medical director recently became director of
12 OHMAS, when the prior director left for a
13 different job. All the cabinet members are
14 looking for jobs, because our governor is going
15 to change, so...

16 Q. If I understand you correctly, the
17 Summit County ADM Board receives some of its
18 funding, some of its dollars, from this state
19 entity, the Ohio Department of Mental Health
20 and Addiction Services?

21 A. Correct.

22 Q. Is it also true that some of the
23 dollars that Summit County receives for the ADM
24 Board come from the federal government?

25 A. Yes.

1 MR. BOEHM: Okay. Let's go off the
2 record.

3 THE VIDEOGRAPHER: Off the record,
4 10:17.

5 (Recess taken.)

6 THE VIDEOGRAPHER: We are back on
7 the record, 10:34.

8 Q. Welcome back, Dr. Smith.

9 When you took this role as the
10 chief clinical officer at the Summit County ADM
11 Board in May 2012, how much did you already
12 know about opioid addiction and its impact on
13 Summit County?

14 A. As of May 1, 2012, not much.

15 Q. Did you know anything?

16 A. I wasn't -- again, I came in with
17 forensic experience, which they were looking
18 for, and, no, opiates was not part of my hiring
19 discussion or anything like that.

20 Q. Did you know that issues related to
21 opioids would be a part of your duties and
22 responsibilities, once you joined the ADM Board
23 as its medical director and chief clinical
24 officer?

25 A. Sure. Alcohol, Drug Addiction,

1 Mental Services Board, I was certainly aware
2 that was part of the scope.

3 Q. But there wasn't anything
4 particular about opioids that you understood
5 would be a part of your responsibility; is that
6 fair?

7 A. That's fair.

8 Q. When you joined the ADM Board in
9 May 2012, what steps did you take, if any, to
10 ensure that you were fully up to speed on the
11 subject of opioid addiction, including causes
12 of the levels of addiction and impacts on the
13 community?

14 MR. KEARSE: Object to form.

15 A. So most of what I did, when I first
16 joined, is I went and met with anybody and
17 everybody at every agency, and the mayor and
18 the county executive, and basically, you know,
19 asked what current issues were, and mostly said
20 I'm here, here's who I am, here's my expertise,
21 if you need me.

22 There was initially no cause, that
23 I was aware of, to do anything particular about
24 opiates.

25 Q. You don't recall opioids in

1 particular coming up in any of your
2 conversations, in your meetings with everybody
3 and anybody?

4 MR. KEARSE: Object to form.

5 A. I'm sure it came up, because we
6 would look at, you know, claims data, things of
7 that nature, but I don't recall any specific
8 discussions until 2013.

9 Q. You indicated that you also met
10 with the county executive when you joined the
11 ADM Board?

12 A. The former one, yes.

13 Q. The former one. Who was that?

14 A. Russ Pry.

15 Q. When did Mr. Pry leave his position
16 as the county executive?

17 A. Unfortunately, he passed away,
18 probably two years ago now.

19 Q. What is the relationship between
20 the ADM Board in Summit County and the office
21 of the county executive?

22 A. So, you know, although we -- so I
23 don't want to over -- make it sound that
24 separate. So we do have a separate board of
25 directors, but we are on the county payroll, we

1 use the county Cronos system.

2 So we really are county employees.
3 All my paychecks come from the county and so
4 forth. It's that we have some separate
5 leadership role, separate from the county
6 executives, so again, because Jerry Craig does
7 not directly report to the county executive.

8 Q. What is the relationship between
9 the Summit County ADM Board and the Summit
10 County Office of the County Executive?

11 A. I guess it depends -- I don't know.
12 It's between Jerry and Ilene Shapiro, how they
13 play that.

14 Q. Does Mr. Craig report in any way to
15 Ms. Shapiro?

16 A. He does not. I will say that our
17 budgets do have to be reviewed by the county
18 council. Everything -- all of our health and
19 human services agencies go through the SSAB
20 review process, and I'm lacking in what that
21 acronym means.

22 But anyway, that is a Social
23 Services Advisory Board, I think is what it is.
24 So they review it, so I mean, we are very
25 connected to the county, but the county

1 executive can't directly tell Jerry what he
2 must do. There is a place where there is a
3 separation.

4 Q. You said that the council reviews
5 ADM Board budgets, right?

6 A. Yes.

7 Q. Do they approve ADM budgets?

8 A. I believe through them and SSAB,
9 they do approve it, yes.

10 Q. What is SSAB?

11 A. Social Services Advisory Board, I
12 believe.

13 Q. Is that an entity under the county
14 executive?

15 A. I'm sure it might be. I don't
16 honestly know. Again, I do clinical, but, yes,
17 I believe they are all tied to county, and they
18 are all reviewing to make sure that the budget
19 is appropriate. It is an extra oversight
20 beyond our board of trustees.

21 Q. Does the office of the county
22 executive also review and approve the ADM Board
23 annual budget?

24 A. Not directly no.

25 Q. Who on the county council is most

1 directly involved in the goings on of the
2 Summit County ADM Board?

3 A. I honestly don't know.

4 Q. Do you have any interaction with
5 anybody on the Summit County Council, as part
6 of your professional duties?

7 A. No. I did go before them once to
8 promote them doing a -- I forget what you even
9 call it, but anyway, to officially decree that
10 we would be a stepping-up county, that is a
11 forensic issue, where we are trying to do,
12 again, jail diversion. That's a nationwide
13 approach. Each county, it's hoped, will sign
14 that. So I'm the one who went before them and
15 presented that, and they did approve it.

16 Q. Okay. When did that happen?

17 A. Probably three and a half years
18 ago.

19 Q. You indicated that when you took
20 this position on as chief clinical officer and
21 medical director for the ADM Board, you met
22 with everybody and anybody to introduce
23 yourself and to, I take it, to understand their
24 understanding of their needs and how the ADM
25 Board could help; is that a fair summary?

1 MR. KEARSE: Object to form.

2 A. It was really more about how they
3 thought I would be able to help. My phrase to
4 every one of them was, I want to be a value
5 add, so here is who I am, here is my
6 background, reach out to me, if you need
7 something I could help with.

8 Q. Do you recall, in those
9 conversations, individuals saying, yes, here is
10 something you could very much help us out with?

11 A. That did not happen much. I think
12 people were okay, and they had to wait and see
13 who I was and so forth. Some of them were such
14 politicians that they spent the time trying to
15 figure out what committee they could appoint me
16 to, so...

17 Q. Did that happen at all, did anybody
18 ever raise a particular issue with you, in
19 those meetings?

20 A. In one meeting I recall, this is
21 happenstance, I was meeting with Donna Skoda,
22 who is our director of public health, and it
23 happened that she got a phone call during the
24 meeting, there two others in the room, public
25 health, and it had to do with refugees, another

1 topic I was unfamiliar with, how we would
2 receive refugees, and then our process to help
3 get them the care they needed and so forth.

4 So that was one time where it
5 happened simply because I was in the room at
6 that time.

7 Q. Did you meet with specialists in
8 addiction medicine?

9 A. Sure.

10 Q. What did you -- what was the
11 purpose of your meetings with addiction
12 specialists?

13 A. They were part of the everybody
14 that I was meeting. So I met at the Summa, at
15 St. Thomas, we have Ignatia Hall, which is an
16 inpatient detox unit, so I met with Dr. Labor,
17 who is their -- was, actually, I don't think
18 she's there now, but their addiction
19 specialist.

20 Along the way, I'm sure I met with
21 Dr. Shane, who is also part of that system, Dr.
22 Garry Thrasher who is our out -- not really
23 outpatient, but sub-acute detox program leader.

24 Q. Did you meet with healthcare
25 providers at Summit-County-affiliated hospitals

1 or practices?

2 A. Yeah, as I just described.

3 Q. Did you meet with the service
4 contractors that ADM pays to handle the
5 services it wishes to provides to residents of
6 Summit County?

7 A. Yes. I went to many of the
8 agencies.

9 Q. In any of those conversations, did
10 the issue in particular of opioid abuse, use or
11 any issues surrounding that come up?

12 A. In 2012, no, not that I recall.

13 Q. Your view is that it wasn't really
14 on anybody's radar in 2012; is that right?

15 A. I would say that is an
16 overexaggeration. I would say it --

17 Q. How would you describe it?

18 A. -- didn't come up, as a topic of
19 conversation in the meetings I was in in 2012.

20 Q. Why do you think it didn't come up?

21 A. They didn't feel they needed it to
22 be something that I was -- they didn't talk to
23 me about it, I guess.

24 Q. All right. Let's turn to the
25 beginning of this exhibit. It's Exhibit 3. It

1 is the 2018 budget.

2 Does the ADM Board prepare a budget
3 every year?

4 A. Yes.

5 Q. Who was responsible for its
6 preparation?

7 A. That would be our director, Jerry
8 Craig, and our director of operations, also
9 CFO, Jennifer Peveich.

10 Q. Anybody else involved in the
11 preparation of the budget?

12 A. I believe that Aimee Wade plays
13 some role in looking at it. I'm sure I've seen
14 it along the way, but again, I'm clinical, I
15 don't do the money stuff.

16 Q. Do you review or approve the
17 budget?

18 A. No.

19 Q. Now, this 2018 budget, I'll
20 represent, is the most recent one we have been
21 able to find, from the production in the
22 litigation. It looks like this one was
23 presented to the board of directors on July 25,
24 2017.

25 Do you know if there has been a

1 more recent budget for -- for example, for
2 2019, that has been presented to the board of
3 directors?

4 A. I believe one is in process, but I
5 don't know that I've seen it, and again, if I
6 do, I mostly just glance at it. It's not my
7 purview.

8 Q. Why do you have an understanding
9 that one is in process; have you seen one?

10 A. I believe that I saw one. I have
11 to say, just my schedule, I missed a couple of
12 board meetings, so that it might have happened,
13 you know, July or August, and I was not at all
14 the meetings. So it is possible that it
15 occurred.

16 I believe Aimee Wade and I were
17 talking, and she mentioned something about a
18 budget.

19 I also know that we are in a levy
20 year, meaning that next November we are on the
21 ballot to get our levy renewed, every six
22 years. So I know there is discussions going on
23 about how to plan for that budgeting. So I'm
24 certainly aware of that.

25 Q. Okay. Is it your understanding

1 that there is a 2019 proposed budget that has
2 been circulated among the members of the ADM
3 Board?

4 MR. KEARSE: Object to form.

5 A. I believe there must have been, but
6 I don't know anything about it.

7 Q. Would you ever receive that by
8 email?

9 A. Possibly.

10 Q. Now, I want you to turn just to the
11 next page of the budget, Exhibit 3. Does this
12 page reflect the Summit County ADM Board's
13 sources of revenue?

14 A. Yes.

15 Q. And it looks like -- well, let me
16 back up.

17 These are the funds that the ADM
18 Board uses to fund its operations; is that
19 right?

20 A. Yes.

21 Q. And these are the funds it uses to
22 fund all of its operations; is that right?

23 A. Almost all of the operations, yes.

24 Q. Are there sources of funds that are
25 not reflected here?

1 MR. KEARSE: I'm going to object to
2 form. And I'm just going to have an objection
3 to going into detail. You can ask him general
4 questions about the budget, but he has
5 already --

6 MR. BOEHM: I don't want any
7 coaching.

8 MR. KEARSE: I'm just saying, he
9 has already testified he's not familiar, he
10 doesn't --

11 MR. BOEHM: You can object to form.
12 Don't coach the witness.

13 MR. KEARSE: I'm putting the
14 objection on the record to going into a
15 document that he has already said he's not
16 familiar with.

17 MR. BOEHM: You have done that, and
18 it's not appropriate for you to coach the
19 witness.

20 MS. KEARSE: I'm not coaching the
21 witness, counsel.

22 MR. BOEHM: Object, and then stop.

23 MS. KEARSE: I'm objecting to going
24 in to spend time -- I said, go ahead and answer
25 the question.

1 MR. BOEHM: He can answer whatever
2 he can answer. That goes without saying. You
3 don't need to make a speech about it.

4 MR. KEARSE: You don't need to be
5 so rude.

6 MR. BOEHM: Object, and then stop,
7 please.

8 Can you go back up to the question
9 that was pending.

10 Q. My question to you is whether or
11 not there were funds at the disposal of the ADM
12 Board that are not reflected here?

13 A. So again, these are projected, but
14 we do, on occasion, where we can, we will apply
15 for grants to leverage our money.

16 So in other words, if we can -- if
17 we are going to work on a program, and we know
18 we can get an extra \$50,000 from the Bureau of
19 Criminal Justice, for example, to do a forensic
20 project, and we have to match it or something,
21 where we can take our 50 grand and turn it into
22 a hundred, we will do that.

23 Q. Okay.

24 A. So that usually happens. Not huge
25 dollars, but that does add to it.

1 Q. Grants would not be reflected on
2 this summary?

3 A. Correct. We wouldn't know about
4 them in advance to project them.

5 Q. Okay. It looks like this is broken
6 down into three categories: federal, state and
7 local; is that right?

8 A. It appears that way, yes.

9 Q. And the federal and state are
10 funding sources that come from outside of
11 Summit County, right?

12 A. Correct.

13 Q. And then the local, those are
14 dollars that are from Summit County; do I
15 understand that correctly?

16 A. Yes.

17 Q. And then, of course, grants, those
18 would also be from outside the county, right?

19 MR. KEARSE: Objection.

20 A. Correct.

21 Q. In terms of the funds that are
22 outlined here, are these earmarked for specific
23 purposes, or can the ADM Board use these
24 dollars in whatever way they see fit?

25 A. I don't know the full answer to

1 that. There are, again, like 25 agencies, so
2 they certainly have planned their budgets based
3 on us funding certain proportions. So a
4 certain percentage of this would certainly
5 be -- much of it would already be, at least, in
6 wet concrete, you know, that we are going to
7 spend this on these agencies. That's the most
8 I can tell you.

9 I don't know, again, I don't know
10 the interworkings of that, but they don't --
11 they can't just suddenly say, we're going to
12 spend \$42 million and buy a blimp or something.
13 No, there is definitely -- it's expected it is
14 spent on services to treat drug addiction,
15 alcohol, mental health.

16 Q. Understood. Let me be more
17 specific. That's a fair point.

18 Of course, I wouldn't expect that
19 the moneys would be spent to, you know, have a
20 carnival, but my question really is, within the
21 parameters of the mission of the Summit County
22 ADM Board, when you receive these funds, is it
23 predetermined that they would be earmarked for
24 specific purposes within that mission, or can
25 you use it however you, as the ADM Board,

1 believe to be appropriate?

2 MR. KEARSE: Object to form.

3 Q. Does that make sense?

4 A. That makes sense.

5 So I believe many times federal and
6 state dollars come with very specific
7 parameters. So we may get -- we may get
8 something from the state that says we
9 specifically want you to work on -- use this
10 for the opioid epidemic or suicide prevention,
11 and so forth.

12 The levy dollars, the bulk of our
13 funds that are local tax levy dollars, I think
14 there is more freedom to determine where the
15 need is, but it's a big process, so it would be
16 steering a big ship. It wouldn't change a lot,
17 from year to year.

18 Q. Who is involved in the
19 decision-making process of how to actually
20 apportion these dollars to whatever purposes
21 the ADM Board has prioritized?

22 A. Well, if you use "involved"
23 broadly, lots of people, because the agencies
24 would certainly be discussing it with Jerry
25 Craig and our CFO. They would talk to the

1 clinical team, to see is there something that
2 we need to be doing more about. Our ADM Board
3 of directors, of course, then ultimately has to
4 decide, yeah, that makes sense to, if we are
5 going to do a shift, in terms of how we might
6 fund something.

7 Q. You mentioned to start the agencies
8 might have something to say about that. What
9 do you mean when you talk about the agencies,
10 which agencies?

11 A. Any of the 25 that we fund. In the
12 process, if somebody was talking to Jerry Craig
13 and saying we have an area that we really need
14 to bolster our budget, so they need an extra
15 100,000 for something, then they -- presumably
16 that's going to be reflected in how the moneys
17 get spent. Obviously, that may mean less money
18 spent in one place, more money spent that
19 place.

20 Q. Are you referring to Summit County
21 government agencies?

22 A. Summit County treatment agencies.

23 Q. That are owned by the county?

24 A. No. They are not government
25 entities. That's why I corrected you.

1 Q. So what do you mean, when you talk
2 about Summit County treatment agencies, are
3 these private entities that -- are these the
4 contracting agencies?

5 A. Correct.

6 Q. Okay. Let's go to the next page.
7 Does this page reflect actual expenditures?

8 MR. KEARSE: I'm going to again
9 object to the form of the question and the
10 foundation.

11 A. I'm not a budget person. It looks
12 like these are projected expenditures.

13 Q. It says Budget Expenditure Summary,
14 and just for the record, we are looking at the
15 page of the document that ends with Bates stamp
16 7933; do you see that?

17 A. Yes.

18 Q. It says Budgeted Revenue and
19 Expenditures, right?

20 A. Yes.

21 Q. And then it has a summary, correct?

22 A. Correct.

23 Q. And it's broken into two
24 categories, one is board administration, and
25 the other is contract services; do you see

1 that?

2 A. Yes.

3 Q. What is the difference between
4 those two categories?

5 A. So actually, that's something we
6 are quite proud of. So we attempt to spend as
7 much of the dollars on actual care, that is
8 through the contract agencies, as opposed to on
9 our rent, salaries, utilities and so forth, and
10 we've kept it -- 6 percent is a target, because
11 many organizations spend a lot more than 6
12 percent on noncare. So 94 percent goes to
13 direct care of patients of Summit County.

14 Q. Then when you look at the contract
15 services, it appears that most of the ADM
16 Board's actual expenditures are directed to
17 mental health; is that a fair characterization?

18 A. Well, it looks like it's the
19 majority of it. It's not a huge difference.

20 Q. Yeah. It's more than half, right?

21 A. Yes.

22 Q. Has that always been the case,
23 since you have been involved with Summit County
24 ADM Board, that most of the funds are directed
25 toward mental health services?

1 MR. KEARSE: Object to form.

2 A. My understanding is that prior to
3 the opioid epidemic, about two-thirds of the
4 dollars actually were spent on mental health,
5 and a third on alcohol and drug addiction
6 treatments, and that because of the epidemic,
7 the number has gotten closer to 50/50.

8 Q. Closer to 50/50, but even today,
9 more than half of the funds expended by ADM
10 Board are directed toward mental health
11 services, correct?

12 MR. KEARSE: Object to the form.
13 The document speaks for itself.

14 Q. Correct?

15 A. Yes.

16 Q. And then you have below the mental
17 health services, a line item for alcohol and
18 drug; do you see that?

19 A. Yes.

20 Q. And here alcoholism and drug
21 addiction are combined into a single line item,
22 right?

23 A. It appears that way, yes.

24 Q. Do you know how this figure would
25 break down if you were to divide it up between

1 alcoholism and drug addiction?

2 A. I do not.

3 Q. Do you have a rough estimate of
4 that?

5 MS. KEARSE: Objection. Asked and
6 answered.

7 A. I don't.

8 MR. BOEHM: Actually, it hadn't
9 been asked and answered.

10 MR. KEARSE: It calls for
11 speculation, too.

12 MR. BOEHM: Object to form is fine
13 and appropriate, and what has been directed.

14 Q. Okay. When you talk about contract
15 services, Dr. Smith, can you describe for us
16 how these contracts are awarded?

17 A. Again, I don't pretend to
18 understand all the logistics. I do know that,
19 ultimately, Jerry does present to the board of
20 directors a list, I think, on a monthly basis,
21 of what contracts we plan to -- he plans to
22 award, and then they do have to approve.

23 I'm not sure how they determine
24 exactly the dollars for any given entity at
25 that point, though.

1 Q. These are contracted medical
2 providers, right?

3 A. Healthcare providers, yes.

4 Q. Healthcare providers. And you are
5 the medical director for the Summit County ADM
6 Board?

7 A. That's correct.

8 Q. Do you have involvement in the
9 process by which contracts are awarded to the
10 medical providers funded by ADM Board?

11 A. Minimally.

12 Q. What is your involvement?

13 A. We may discuss -- we have periodic
14 meetings, at least a couple times a month,
15 where Jerry Craig and I meet and talk about,
16 kind of, where things are at, but not money.

17 So my influence would be clinical
18 input on where things are at, but as far as,
19 "Gee, therefore, please spend a million here
20 and not here," would not be my role.

21 Q. Do you have insight into who you
22 think is doing a good job and who is not?

23 A. Insight, sure, but most of what we
24 do is as data driven as possible, so we can
25 see, based on the audits and everything else,

1 who's doing the -- who seems to be getting the
2 better outcomes.

3 Q. Who is involved in that process of
4 generating and analyzing the data in connection
5 with the decisionmaking about awarding
6 contracts?

7 A. Many people on the clinical team,
8 as on the TO you showed me would be doing
9 audits. Aimee Wade puts those together, and
10 then they get discussed.

11 Q. And are you part of that process?

12 A. I'm sure I've seen audit reports,
13 but I'm not, again, making decisions on how
14 much money gets spent one place or the other.

15 Q. Well, earlier this morning, you
16 talked about how important it was for the
17 Summit County ADM Board to ensure that you were
18 getting the best bang for your buck from these
19 service providers, right?

20 A. That's correct.

21 Q. And you talked about the need to
22 audit, and you talked about the need to provide
23 some oversight over these contract providers,
24 right?

25 A. Correct.

1 Q. And you said you were involved in
2 that, right?

3 A. That's correct.

4 Q. Can you describe for us, in more
5 detail, what that auditing and oversight
6 responsibility involves?

7 A. I can tell you for myself. So for
8 me, I do run a quarterly meeting, where I meet
9 with the medical directors for all the agencies
10 that have a medical director, I actually
11 include the two big hospital systems in that,
12 and then the following month, but again
13 quarterly -- I just had this recently -- I run
14 a clinical leaders meeting, because not
15 everybody has got a medical director, a
16 clinical leaders meeting, and so we do
17 discuss -- I leave it open, most of the agenda
18 is open to the agencies to talk about things
19 they are doing, things they see a need for, and
20 so forth.

21 Quite frankly, most of it ends up
22 being me talking and maybe my clinical team
23 talking, but -- so that's one of the ways.

24 I also meet with the main medical
25 directors, one-on-one, once a month to talk

1 about how they see things going, what they
2 think their needs might be and so forth.

3 Q. Do the service contractors or
4 entities that wish to be service contractors
5 submit a bid to the ADM Board for the scope of
6 work requested?

7 A. They do prepare a budget. I
8 believe that our CFO sees their entire budget,
9 and then within the portion they believe, they
10 hope, will come from ADM, and then they do that
11 process.

12 Q. So they do submit a bid?

13 A. I don't know if you would call it a
14 bid. I think they have a negotiation.

15 Q. Okay. Is each contract that is
16 awarded defined to a specific scope -- specific
17 scope of work?

18 A. Well, each of the agencies has,
19 through OHMAS, has certainly certification to
20 do certain types of scope of work. So
21 certainly they would be held to that, whatever
22 that standard is.

23 Some are certified specifically for
24 mental health, some specifically for addiction,
25 and some actually now, really are required by

1 the opioid epidemic, have become dual
2 certified, because there has been so much
3 overlap.

4 Q. But when the ADM Board says to an
5 entity, here is some money, and we want you to
6 spend it in a certain way, does that get
7 written down in a contract, is there some
8 recordkeeping mechanism so that you can then
9 follow up and provide the oversight that you
10 said was important?

11 MR. KEARSE: Object to form. I
12 think it misstates his testimony.

13 A. There is a contract annually with
14 each entity, yes.

15 Q. Where is that -- where are those
16 contracts kept, who has those?

17 A. I'm sure that Jerry Craig and the
18 director of operations have them.

19 Q. Okay. Do you have those?

20 A. I do not.

21 Q. Going back up to this line item for
22 alcohol and drug, just to be clear, this is a
23 comprehensive figure that reflects Summit
24 County's expenditures for alcoholism and drug
25 addiction relating to all drugs, correct?

1 A. Correct.

2 Q. So that involves cocaine, meth,
3 heroin, marijuana, and the list goes on,
4 correct?

5 MS. KEARSE: Object to form.

6 A. I believe it is comprehensive of
7 all potentially addictive substances, yes.

8 Q. Is it possible to break that figure
9 down, in terms of how much is spent on any
10 particular drug?

11 A. Presumably, the fiscal side could
12 at least say if somebody is being treated for
13 an opiate-use disorder versus an alcohol-use
14 disorder. That is probably achievable.

15 Q. If you look at the bottom of this
16 page 7933, do you see the line that says,
17 "Projected revenue over/under expenditures"?

18 A. Yes.

19 Q. And for 2018, it is in parentheses,
20 does that mean that the expenditures are
21 greater than the revenue?

22 A. Yes.

23 Q. And can you describe what that
24 means?

25 MR. KEARSE: Object to form.

1 A. Well, mathematically, it means we
2 spent more money than we brought in through
3 those three sources.

4 Q. And does the ADM Board have, kind
5 of, money in reserve that it can apply to those
6 expenditures?

7 A. Yes. We have a fund balance, based
8 on what wasn't spent in other years, and then
9 gradually that often gets spent down pretty
10 low, by the time we have a levy.

11 Q. So in this case, this figure here
12 in parentheses for 2018, would the ADM Board
13 draw upon existing -- an existing account to
14 cover that expense?

15 MR. KEARSE: Object to form.

16 A. That's my understanding, yes.

17 Q. If you turn to page 11 in the upper
18 right-hand corner of this, it looks like that
19 for many years, the ADM Board had revenue that
20 exceeded its expenditures. I'm looking here at
21 the projected revenue over/under expenditures
22 line on at the bottom of page 11.

23 A. Yes.

24 Q. Do you see that?

25 So for 2009, for example, revenue

1 exceeded expenditures by over 12 million
2 dollars; am I reading that right?

3 A. Yeah. That's what it says.

4 Q. And then in 2010, by 10 and a half
5 million dollars?

6 A. Yes.

7 Q. What is your understanding of what
8 that means?

9 A. The dollars that came in through
10 the levy and perhaps other, you know, federal
11 and state sources exceeded what was spent.

12 Q. I'll direct your attention to page
13 8 of this same document, Dr. Smith. It's
14 entitled 2008 Contract Expenditures By Agency;
15 do you see that?

16 A. Yes.

17 Q. Does this page reflect the entities
18 which have been awarded service contracts by
19 the Summit County ADM Board in 2008?

20 A. It appears to.

21 Q. Okay. This is again broken down
22 into two categories, mental health, and then
23 alcoholism and drug addiction are combined,
24 right?

25 A. Yes.

1 Q. If you look down toward the bottom
2 the page, there are two line items that refer
3 specifically to opiates, one is the 21st
4 Century Cures Act, OMHAS Opiate Grant; do you
5 see that?

6 A. I see that.

7 Q. What is that?

8 A. So I believe under the Obama
9 administration, one of their last legislative
10 actions was to create the 21st Century Cures
11 Act, and so that provided a certain amount of
12 dollars to each state to provide treatment and
13 fight the opiate epidemic, and that was the
14 portion that then filtered through the state,
15 which then means Ohio Department of Health and
16 Addiction Services, down to our county.

17 Q. Okay. This is a grant from the
18 federal government that went through some state
19 agency, and ultimately Summit County got some
20 of that money; is that right?

21 A. That's my understanding, yes.

22 Q. The one below that, the next one on
23 the list, says Targeted Solutions, dash, Opiate
24 Epidemic; do you see that?

25 A. Yes.

1 Q. What is that?

2 A. By that phrase, I don't know.

3 Q. You're not sure what this line item
4 refers to?

5 MR. KEARSE: Object to the form,
6 and asked and answered.

7 A. No, I don't, not specifically.

8 Q. Who would we need to ask to get the
9 answer to that question?

10 A. Again, either Director Jerry Craig
11 or Jennifer Peveich, our CFO.

12 Q. You don't recall being involved in
13 any discussion about a targeted solutions line
14 item related to the opiate epidemic?

15 A. Not by that phrase. I'm sure it is
16 tied to our Opiate Task Force and all of the
17 many things that have been happening.

18 Q. Well, whether it's by this phrase
19 or not, do you know what this refers to?

20 MR. KEARSE: Object to form and
21 asked and answered.

22 A. Again, it says "solutions," so they
23 have done a lot of things in the county. I
24 assume it is money that was spent to fund those
25 programs.

1 Q. Okay. Do you know what programs it
2 was funding?

3 MR. KEARSE: Object to form. I'm
4 just going to direct the witness not to guess
5 as well. So he has already answered. He's
6 told you specifically, to that line budget
7 item, he does not know what that refers to.

8 MR. BOEHM: When the attorney is
9 done, can you just go back up to my question
10 and read it back, please.

11 THE NOTARY: Question: "Do you
12 know what programs it was funding?"

13 A. So I know what programs ADM, at
14 least some of them, what we fund, but I don't
15 know if that's what this line item is about.

16 Q. Do you know what the source of
17 funds are for this particular line item?

18 MR. KEARSE: Object to form. Asked
19 and answered.

20 A. I do not.

21 Q. Which of the services contracts
22 that are reflected here for 2018 relate, in
23 particular, to opioid addiction and
24 opioid-related issues?

25 A. Again, I can only read what you can

1 read. So 21st Century Cures says opiates;
2 Targeted Solutions - Epidemic Opiates, says
3 opiates. But opiates have affected so many in
4 our population, that I'm sure there is overlap
5 in virtually every one of them.

6 Q. Okay. But you know what these
7 entities are, right, as the medical director
8 for the Summit County --

9 A. Certainly.

10 Q. -- ADM Board?

11 A. Yes.

12 Q. And you know the services that they
13 have been contracted to render; don't you?

14 A. At least broadly, yes.

15 Q. Which of these service contractors
16 and contracts relate, in particular, to opioid
17 addiction?

18 A. Well, all of the ones in the lower
19 half that says Alcohol/Substance Use Services
20 certainly have worked with individuals with
21 opiate-use disorder. Ones that are really
22 targeted, that's very, very specifically,
23 UMADAOP for sure; community health center is
24 our largest addiction treatment agency; Edwin
25 Shaw is also a treatment agency for substance

1 use, I'm sure, therefore, opiates; Interval
2 Brotherhood Home is our largest residential
3 treatment program for addiction, they -- we
4 have a lot of discussions with them. A lot of
5 their people are there for opiate-use disorder
6 treatment.

7 Mature Services, now called Vantage
8 Aging, is what it sounds like, it's older
9 adults. Again they have a whole section that's
10 on treatment of addiction. Oriana House is all
11 about addiction. They work with the criminal
12 justice service for addiction, and then, in
13 particular for us, they run our detox center,
14 which is mostly, in the recent years, has been
15 seeing opiate addiction, as opposed to any
16 other addiction.

17 The Summit County Community
18 Partnership is -- specifically, has been
19 spending their time working on fighting the
20 opiate epidemic, giving out Detera bags,
21 giving lectures and so forth.

22 Summit County Public Health, again
23 there is a lot of overlap there, because they
24 work with the whole public sphere of health.
25 They do a lot. They distribute the Dawn kits,

1 the naloxone kits to hopefully save lives
2 during an overdose. The DARE program is the
3 law enforcement approach in schools to prevent
4 individuals from starting to use drugs.

5 Q. Okay. Thank you.

6 Are any of these entities that you
7 have just, kind of, ticked through devoted
8 exclusively to opioid addiction?

9 A. Not exclusively, no.

10 Q. Are you able to break down what
11 proportion of the funds that are given to these
12 contracting agencies actually get directed
13 specifically to opioid treatment, as opposed to
14 treatment of other alcohol or substance abuse
15 disorders?

16 A. Personally, I'm not, no.

17 Q. Do you have somebody at the ADM
18 Board who could do that?

19 A. I'm sure, based on the claims data,
20 they could decide what the person was at, say,
21 Interval Brotherhood Home, what addiction are
22 you here for, yes, they could on that.

23 Q. Who would we ask about that, at the
24 ADM Board board?

25 A. Again, Jerry Craig is your best

1 source.

2 Q. I saw a reference to Ms. Peveich,
3 and I think you've referenced her before as
4 well?

5 A. Yeah. Jen Peveich. So she's our
6 director of operations/chief financial officer.
7 She is our money person.

8 Q. So as the chief financial officer,
9 is she also somebody that we could ask about
10 that?

11 A. Certainly.

12 Q. What is the total cost to Summit
13 County, in relation to the opioid crisis,
14 during the years that you have been the chief
15 clinical officer and medical director for the
16 Summit County ADM Board?

17 MR. KEARSE: Object to form.

18 A. Again, I don't know the dollar
19 figure. Clinically, it's hundreds of lost
20 lives.

21 Q. Do you know what the number is?

22 A. I do not. I'm sure it's many
23 millions, but other than that, I couldn't -- I
24 can't guess that, no.

25 Q. Would we have to ask Ms. Peveich?

1 A. Yes.

2 THE VIDEOGRAPHER: May I change the
3 tape at this point?

4 MR. BOEHM: You need a break?

5 THE VIDEOGRAPHER: Yes, to change
6 the tape.

7 MR. BOEHM: Yes.

8 THE VIDEOGRAPHER: We are off the
9 record at 11:15.

10 (Pause.)

11 THE VIDEOGRAPHER: We are back on
12 the record, 11:17.

13 - - - - -

14 (Thereupon, Deposition Exhibit 4,
15 August 14, 2017 Email From Jennifer
16 Peveich, Beginning with Bates Label
17 SUMMIT 902497, was marked for
18 purposes of identification.)

19 - - - - -

20 Q. I'm going to hand you the next
21 exhibit to your deposition today. It's marked
22 as Exhibit 4.

23 This is an August 14, 2017 email
24 from Ms. Jennifer Peveich, and she wrote this
25 email to you, to Mr. Jerry Craig, and to Ms.

1 Mary Alice Sonnhalter; do you see that?

2 A. I do.

3 Q. Do you know see that the subject of
4 this email is, "Draft opioid cost and
5 demographic information"?

6 A. I see that.

7 Q. She writes that she's providing to
8 you a draft of information that was requested
9 by the Summit County Executive's office; do you
10 see that?

11 A. I see that.

12 Q. And that the request from the
13 Summit County Executive's office was related to
14 the cost of opiate use to the county for the
15 years 2012, 2013, 14, 15 and 16; do you see
16 that?

17 A. I see that.

18 Q. Do you recall seeing this email
19 from August of last year?

20 A. Yes. I'm sure I saw it, yes.

21 Q. Who from the Summit County
22 Executive's office made the request for a
23 calculation of total costs of opiate use to
24 Summit County for the years 2012 to 2016?

25 A. I think it was actually the county

1 executive.

2 Q. It was Ms. Shapiro?

3 A. Yes.

4 Q. Why -- what is your understanding
5 as to why Ms. Shapiro requested this cost
6 analysis?

7 A. She was relatively new, and I
8 believe she was working on a, whatever you call
9 it, state of the county speech, and she wanted
10 to be able to talk cogently about the epidemic.

11 Q. Did you ever speak personally to
12 anyone in county government about this request?

13 A. I did not.

14 Q. And this task fell to Ms. Peveich,
15 for the reasons that you have described,
16 correct?

17 A. Correct.

18 Q. She is the right person to ask this
19 question of, right?

20 A. Definitely the right person.

21 Q. And if you turn to the next page,
22 we can see the attachment to Ms. Peveich's
23 email, right?

24 A. Correct.

25 Q. This is where she estimates total

1 costs to Summit County related to opiate use
2 from 2012 to 2016, right?

3 A. Yes.

4 Q. And if you just take a look through
5 all the numbers, she comes to a grand total of
6 approximately 25 million dollars, total cost to
7 Summit County related to opiate use for the
8 years 2012 to 2016, correct?

9 A. Yes.

10 Q. Do you recall seeing this analysis?

11 A. I recall it. I wouldn't have
12 remembered the numbers, but, yes, I recall it.

13 Q. Do you recall having a reaction to
14 this analysis?

15 A. No. I knew we were spending tens
16 of millions on it, so, no.

17 Q. Did this number surprise you?

18 MR. KEARSE: Object to form. Asked
19 and answered.

20 A. No.

21 - - - - -

22 (Thereupon, Deposition Exhibit 5,
23 August 14, 2017 Email Exchange,
24 Beginning with Bates Label SUMMIT
25 902513, was marked for purposes of

1 identification.)

2 - - - - -

3 Q. Giving you a document that's been
4 marked as Exhibit 5, this is the continuation
5 of your email exchange with Ms. Peveich from
6 August of last year; do you see that?

7 A. I do.

8 Q. You wrote back to Ms. Peveich,
9 "Wow, 25 million"; do you see that?

10 A. Yes, I do.

11 Q. Why did you write, "Wow, 25
12 million"?

13 A. I don't recall. I also wrote,
14 "Looks pretty thorough." I'm not the numbers
15 person, so...

16 Q. My question to you is, this is
17 something you wrote, right --

18 A. It is, yes.

19 Q. -- "Wow, 25 million"?

20 A. Uh-huh.

21 Q. When did you mean when you wrote,
22 "Wow, 25 million"?

23 MR. KEARSE: Asked and answered.
24 Object to form.

25 A. I don't recall, but obviously, you

1 tell me you want to give me a check for 25
2 million, I'm going to say, "Wow, that's a lot
3 of money."

4 Q. So you were said, "Wow, 25
5 million," you were saying that's a lot of
6 money?

7 A. Right.

8 Q. Did you expect it to be less?

9 A. No. I don't think I had --

10 MR. KEARSE: Object to form.

11 A. I don't think I had an expectation,
12 but it's a lot of money.

13 Q. And then you wrote, as you
14 mentioned, "Looks pretty thorough." What did
15 you mean by that?

16 A. That it looks like she had gone
17 through all the possible expenditures and come
18 up with an accurate number.

19 Q. Do you know if that's the analysis
20 that actually was submitted to the county
21 executive, in response to Ms. Shapiro's
22 request?

23 A. I honestly don't know.

24 Q. You don't know of any changes
25 having been made to that analysis, do you?

1 MR. KEARSE: Objection. Asked and
2 answered. He testified he doesn't know.

3 A. Yeah, I don't know.

4 Q. The answer is you are not aware of
5 any --

6 A. I'm not.

7 Q. -- changes having been made, right?

8 A. Correct.

9 - - - - -

10 (Thereupon, Deposition Exhibit 6,
11 August 18, 2017 Email Exchange,
12 Beginning with Bates Label SUMMIT
13 902806, was marked for purposes of
14 identification.)

15 - - - - -

16 Q. And here is a document that has
17 been marked as Exhibit 6 for this deposition.
18 This is still from August 2017, and Ms. Peveich
19 here is following up, asking whether anybody
20 else has any comments or suggestions; do you
21 see that?

22 A. Yes.

23 Q. And you wrote back to Ms. Peveich
24 saying, "None. Looks solid as is"; do you see
25 that?

1 A. I do.

2 Q. What did you mean by that?

3 A. Similar to my "pretty thorough"
4 response, it looked like I couldn't give a
5 reason to think there was something faulty
6 about her calculations.

7 Q. And, in fact, they looked thorough
8 and looked solid to you, right?

9 A. Yes.

10 Q. You indicated earlier that you
11 joined the ADM Board in May 2012, right?

12 A. Correct.

13 Q. But you said, I think, earlier, if
14 I heard you right, that you didn't know that
15 there was this opioid, as you put it, epidemic
16 happening until sometime in 2013; did I hear
17 your testimony correctly about that?

18 A. That's correct.

19 Q. Do you recall, Dr. Smith, that in
20 reality, you attended an opiate conference in
21 May 2012, the very month that you started at
22 the ADM Board?

23 MR. KEARSE: Object to form.

24 A. The only conference I recall
25 attending would have been one that the family

1 medicine put on from NEOMED, and I don't recall
2 if it was opiates or not.

3 - - - - -

4 (Thereupon, Deposition Exhibit 7,
5 May 8, 2012 Agenda, Ohio's Opiate
6 Summit, was marked for purposes of
7 identification.)

8 - - - - -

9 Q. This is a document I have marked as
10 Exhibit 7. It is a May 8, 2012 agenda for
11 something called Ohio's 2012 Opiate Summit,
12 Miles Traveled, Miles Ahead. Does this look
13 familiar to you?

14 A. Honestly, it goes not, but...

15 Q. Do you recall having attended this
16 conference?

17 A. I don't, actually. I know many of
18 the presenters, but I don't recall this
19 particular conference.

20 Q. Do you recall registering for this
21 conference?

22 A. It's been a lot of years. No.
23 I've registered for lots of conferences.

24 Q. I'll represent that the county has
25 produced data to us that shows that you

1 registered for this conference in May of 2012;
2 does that ring a bell for you?

3 A. I won't refute it, but...

4 MR. KEARSE: Object to form. I'm
5 not going to have you ask questions about a
6 conference he doesn't recall going to. So, you
7 know, if you want to show him that he was
8 actually there.

9 MR. BOEHM: I'm going to ask
10 whatever questions I want to ask, and you can
11 object to form. You gave us data that showed
12 that he registered and attended the conference,
13 so...

14 MR. KEARSE: If he doesn't recall
15 attending the conference.

16 MR. BOEHM: Then let me ask the
17 question.

18 MR. KEARSE: I did. You did ask
19 the question, and he doesn't recall going to
20 the conference.

21 MR. BOEHM: Okay. So what are
22 you -- what are you doing right now? Do you
23 want me to examine you, or can I turn back to
24 the doctor?

25 MR. KEARSE: I would like to have a

1 civil conversation --

2 MR. BOEHM: I'm just not sure what
3 record you're making right now.

4 Q. Dr. Smith, do you know what the
5 OACBHA is?

6 A. Yes.

7 Q. What is that?

8 A. I don't remember the acronym, but
9 basically, OACBHA, as we say, is the
10 organization that represents all of the ADM
11 Boards across the state.

12 Q. Okay. And my counsel -- my
13 colleague has just reminded me that this
14 conference that is described in the agenda and
15 marked as Exhibit 7 was hosted by the OACBHA
16 and produced data showing that you registered
17 for this conference.

18 MS. KEARSE: And, counsel, I would
19 like to know the Summit -- the number that
20 shows this was produced by Summit County.

21 MR. BOEHM: This particular agenda
22 was produced by the OACBHA.

23 MR. KEARSE: Okay. So it was not
24 produced by Summit County. So counsel has not
25 provided you with this information, and I would

1 like to correct the record.

2 MR. BOEHM: I just said that the
3 OACBHA produced this information, pursuant to
4 third-party subpoena.

5 MR. KEARSE: Right. Earlier you
6 suggested that counsel provided you with this
7 information --

8 MR. BOEHM: I just --

9 MS. KEARSE: -- from the Summit
10 County files.

11 MR. BOEHM: I just clarified that
12 myself.

13 MR. KEARSE: Okay. Because I just
14 asked you to clarify it.

15 MR. BOEHM: No. I clarified it
16 before you jumped in. Regardless --

17 MR. KEARSE: I wanted -- to the
18 extent you are going to suggest that the
19 witness was at this conference when he just
20 testified he wasn't at the conference or
21 doesn't recall the conference, I'm just going
22 to --

23 Q. Dr. Smith, did you testify that you
24 did not attend this conference?

25 A. No. I just don't recall.

1 Q. And if we have data from the OACBHA
2 reflecting that you registered for this
3 conference, you are not going to refute that,
4 right?

5 A. Not that I registered, no.

6 MR. KEARSE: Can I see the
7 document, please?

8 MR. BOEHM: What document?

9 MR. KEARSE: The one that you are
10 referencing that suggests he registered there.
11 I just would like to see the document that you
12 have in front of you.

13 MR. BOEHM: I'm going to conduct
14 this deposition. If you want to follow up
15 later, you can do that. But I represented it
16 for the record.

17 MR. KEARSE: Okay. Well, you have
18 it right in front of you. If you could show it
19 to me.

20 MR. BOEHM: It's a printout from
21 the database that you have access to. So if
22 you want to go look it up --

23 MR. KEARSE: What's the Bates --

24 MR. BOEHM: -- from OACBHA --

25 MS. KEARSE: Is there a Bates

1 number on it?

2 MR. BOEHM: We can talk off the
3 record. I'm not going to waste more of our
4 time here.

5 Q. You don't recall attending this,
6 Dr. Smith --

7 A. Being the fifth business day that I
8 was working the ADM board, no, I do not.

9 Q. Right. Well, that's why I thought
10 it was interesting as well. This was just a
11 matter of days after you joined the ADM Board,
12 right?

13 A. Correct.

14 Q. Is this something that would have
15 been of interest to you, as the medical
16 director for the Summit County ADM Board?

17 A. Certainly. I went to as many
18 clinical, and still do, clinical conferences
19 that I can, so...

20 Q. And you can see that the subject of
21 this conference is opioid abuse, right?

22 A. Well, it says, "Opiate Summit." So
23 it's something about opiates.

24 Q. Yeah. If you look at it, Dr.
25 Smith, you can see, for example, Dr. Orman

1 Hall; do you know who that is?

2 A. Not doctor, but, yes, he was the
3 director -- he was the director of ODMHAS.
4 This is, again, before the departments merged.

5 Q. And he gave a presentation at this
6 conference entitled Driving the AOD System
7 Response to Opiate Abuse in Ohio; do you see
8 that?

9 A. Yes.

10 Q. And then Mr. DeWine, now
11 Governor-Elect DeWine, gave a presentation
12 about Detouring Illegal Activity, right?

13 A. Yes.

14 Q. And the title of the conference is
15 Ohio's 2012 Opiate Summit.

16 A. Right.

17 Q. Fair to say that this was an agenda
18 for a conference on the subject of issues
19 related to opioid addiction and abuse in the
20 state --

21 MS. KEARSE: Object to form.

22 Q. -- fair?

23 A. Yes.

24 Q. Do you recall attending any
25 conferences related to opiate abuse in 2012?

1 A. Again, to place it in exact date
2 and time, no.

3 Q. Do you recall, as part of your
4 efforts to try to understand the issue of
5 opiate abuse, going back and looking for
6 reports by any task forces or any other
7 entities that were charged with the
8 responsibility of trying to identify causes of
9 opiate abuse; did you do that?

10 MR. KEARSE: Object to form.

11 A. Sure. At the time, not there
12 anymore, Aimee Wade's predecessor, John Ellis,
13 who really was our -- I came in as our forensic
14 expert, he came in as our addictions expert
15 about six months before me, I think.

16 So he was mostly the one collecting
17 information and sharing it with me. When it
18 became clear that we had a lot of problem with
19 opiate overdose deaths, I actually then,
20 instead of attending the usual conferences I go
21 to in October, I went to a national conference
22 of the American Academy of Addiction
23 Psychiatrists, to try to enhance my education.
24 It would have been December of 13 or 14,
25 something like that, I think.

1 Q. In the year 2012, when you came
2 into the position of medical director for the
3 Summit County ADM Board, did you undertake to
4 try to identify and review any task force work
5 product on the subject of opioid abuse?

6 MR. KEARSE: Object to form.

7 A. I may have -- so Cuyahoga County
8 did start their Opiate Task Force before ADM,
9 and I don't know if it was in 12, but certainly
10 I went to some of their meetings, as we were
11 planning our Opiate Task Force in Summit
12 County, which we launched in early 14.

13 So I certainly went to
14 their -- those task forces, went to whatever
15 opportunities were offered; therefore, I'm not
16 surprised if I went to this. I may have gone
17 to this, but do I recall the content, no.

18 Q. Well, certainly if you went to this
19 conference in May 2012, just days after you
20 started as the medical director at Summit
21 County ADM, you certainly wouldn't say it
22 wasn't until 2013 that you became aware that
23 there were issues related to opiate abuse that
24 merited particular attention?

25 MR. KEARSE: Object to form.

1 Mischaracterizes his testimony.

2 A. No. All I'm saying is my
3 recollection was, and probably because we
4 started doing a lot of things in 2013, that it,
5 kind of, hit that high mark in 2013.

6 So perhaps I learned something in
7 12, but 13 is when we started to act on it with
8 various projects.

9 Q. Okay. Well, that's an important
10 distinction. Your testimony is that you really
11 started to act on the opioid epidemic as part
12 of the Summit County ADM Board in 2013, but you
13 were aware of the opioid epidemic before that,
14 fair?

15 MR. KEARSE: Object to form.
16 Mischaracterizes his testimony.

17 A. I don't recall being aware, whether
18 I went to this conference or not.

19 Q. Well, if you went to this
20 conference, that would certainly suggest you
21 were aware, right?

22 A. Right.

23 Q. And if you had looked for reports
24 that were produced by opiate-specific task
25 forces that were produced before 2012, that

1 also would suggest that you were aware before
2 2013 about the opioid epidemic, correct?

3 MR. KEARSE: I'm going to object to
4 form.

5 Are you okay?

6 MR. MASTERS: Yes. Sorry.

7 A. Yes. I mean, there is no doubt
8 that my very nature would be to start working
9 on trying to figure it out and help it as soon
10 as I was aware.

11 I'm just, again, important to you,
12 not important to me, in my mindset. I would
13 have started acting on it as early as I could
14 have.

15 Q. You would have wanted to research
16 this issue as quickly as you possibly could
17 have, right?

18 MR. KEARSE: Object to form.

19 A. Certainly.

20 Q. So if, for example, there was a
21 task force report from 2010 that described
22 opioid abuse in Ohio as an epidemic, that's
23 something you would have wanted to identify,
24 read and understand --

25 MS. KEARSE: Object.

1 Q. -- as part of your responsibilities
2 as the clinical director for Summit County ADM
3 Board; is that fair?

4 MR. KEARSE: Object to form.

5 A. Yes. I would have wanted that even
6 from some other states, sure.

7 Q. Do you recall undertaking that kind
8 of effort, to identify reports or writings or
9 articles that would help inform your
10 understanding of opioid abuse?

11 A. I do. I don't know timeframes, but
12 I certainly did -- I recall doing some
13 in -- learning something about -- I think they
14 had an earlier issue in New England, maybe
15 Maine in particular. So I was looking for
16 information from what they were doing.

17 Again, I went to a conference I
18 wouldn't have normally -- previously gone to,
19 the American Addiction -- American Academy of
20 Addiction Psychiatrists conference, to be
21 amongst the experts, to learn, multiple
22 lectures and stuff about that.

23 And then once I was up to speed, I
24 started helping put on our own conferences.

25 Q. So you don't know, sitting here

1 today, exactly when you learned about the
2 opioid epidemic in Ohio and specifically in
3 Summit County; is that correct?

4 MR. KEARSE: Object to form.

5 A. Correct. I know it was not while I
6 was at Northcoast, and it was sometime after I
7 joined the ADM board.

8 Q. And your testimony, if I understand
9 it correctly, is that when you joined the ADM
10 Board, you would have undertaken, as quickly as
11 possible, to try and understand what was
12 happening in Summit County, with respect to
13 opioid abuse; is that fair?

14 MS. KEARSE: Object to form.

15 A. Once it was raised as an issue of
16 concern, yes.

17 Q. And you indicated that at some
18 point, after undertaking that effort, you
19 yourself started to have and host conferences
20 on the subject of opioid abuse in Summit
21 County, right?

22 A. Yes.

23 - - - - -

24 (Thereupon, Deposition Exhibit 8,
25 Pamphlet Entitled The Role of the

1 Physician in Prescription Drug
2 Abuse, Beginning with Bates Label
3 SUMMIT 930645, was marked for
4 purposes of identification.)

5 - - - - -

6 MS. KEARSE: A perfectionist.

7 MR. BOEHM: Can you tell? I want
8 to put it there so much. It wasn't happening.

9 Q. I just marked a document as Exhibit
10 8. Do you remember this document? And I'll
11 just say for the record, it is a pamphlet
12 related to a May 31, 2014 conference entitled
13 The Role of the Physician in Prescription Drug
14 Abuse. Do you recall this?

15 A. Yes.

16 Q. What this is?

17 A. So Dr. Thrasher, who is our
18 addiction expert at our detox center, and I
19 started talking about we need to do something
20 to educate physicians.

21 We did create a healthcare
22 subcommittee for the Opiate Task Force that
23 started in early 2014, but even before that, we
24 started looking at -- in 13, we started looking
25 at we need a way to educate the physicians, and

1 not just psychiatrists, we meant primary care
2 and so forth, physicians about prescriptions
3 and the fact that they were leading to
4 addiction. So that was -- we set forth to
5 create a conference.

6 Q. Were you responsible for organizing
7 the conference?

8 A. Both Dr. Thrasher and I, yes.

9 Q. And you and Dr. Thrasher delivered
10 the opening remarks for this conference, right?

11 A. That's correct.

12 Q. Were you the individuals, you and
13 Dr. Thrasher, who were responsible for
14 identifying and inviting the speakers for this
15 conference?

16 A. Yes.

17 Q. How did you go about identifying
18 appropriate speakers for this conference?

19 A. Well, our goal was to move quickly.
20 In this case, we didn't want to wait a long,
21 long time to get the first conference going.
22 So we went with individuals we were both aware
23 of in the Northeast Ohio region who were
24 addiction specialists, as well as Dr. Kohler,
25 who is our -- is and was our Summit County

1 Medical Examiner, to give her perspective on
2 what was happening.

3 Q. In your view, are all the doctors
4 who presented at this conference that you had
5 organized respected in the medical community?

6 A. Yes.

7 Q. And they had some expertise with
8 respect to prescription drug abuse that you
9 thought would be helpful for other doctors to
10 hear about, right?

11 A. Yes.

12 Q. The first speaker after you and Dr.
13 Thrasher is Dr. Christina Delos Reyes; do you
14 see that?

15 A. Yes.

16 Q. Who is that?

17 A. She is the director of the
18 addiction fellowship program up at Case Western
19 Reserve University.

20 Q. Was she the keynote speaker?

21 A. Nobody was a keynote. They were
22 all very important.

23 Q. Do you recall if the speakers
24 developed slides and presented slides for this
25 conference?

1 A. At least some of them, I'm sure,
2 did, yes.

3 Q. Did you receive copies of those
4 slides?

5 A. I believe we actually posted them,
6 at some point, on our website.

7 Q. The ADM Board website?

8 A. Yes.

9 Q. Do you know if those would still be
10 available there?

11 A. I don't know if they are still on
12 the website. I'm sure they are available
13 somewhere.

14 Q. Where would we go to try and find
15 all of those slides developed for this
16 conference?

17 A. I actually believe they were part
18 of the large, beyond a flash drive, whatever it
19 was, of stuff that we sent in the discovery
20 process.

21 Q. You mean to the lawyers --

22 A. Right.

23 Q. -- for Summit County?

24 A. They should be in the whole big
25 database.

1 Q. Okay. And the next speaker is Dr.
2 Lisa Kohler.

3 A. Correct.

4 Q. Who is that?

5 A. She is then and now is the Summit
6 County Medical Examiner. She is a trained
7 forensic pathologist.

8 Q. Right. And then getting later on
9 in the day, Ms. Ann DiFrangia -- I don't know
10 that I pronounced that correctly -- spoke about
11 the OARRS database; do you see that?

12 A. I do.

13 Q. Who is Dr. DiFrangia?

14 A. She is an addiction specialist at
15 what used to be called Edwin Shaw Rehab
16 Hospital. They -- when Cleveland Clinic took
17 over, they changed the name to something else
18 at this point, but she is still at that agency
19 here in town as part of the Cleveland Clinic.

20 Q. What is the OARRS database?

21 A. So OARRS is the Ohio version -- I
22 always forget the initials, OENDP, or
23 something, program, where basically a physician
24 can go in and ultimately, by law, it became
25 required, it wasn't yet at that point, go in by

1 law, and look up a patient's profile of
2 prescriptions, to make sure, basically, they
3 are not doctor shopping. That was the original
4 purpose.

5 So, like, when I -- if I were to
6 prescribe Ambien for sleep, because, again, I
7 don't prescribe opiates, but as a controlled
8 substance, I would look up John Jones, I have
9 to put a date of birth and a zip code, I think
10 that zip code is anywhere he lived in the last
11 ten years -- actually, it's a pretty thorough
12 database.

13 It will then pull up and show me
14 the physicians, the medications, the dosages,
15 the number of pills, the pharmacy, and then
16 that allows me to make sure he didn't just get
17 some Ambien three days ago from his primary
18 care doctor and so forth.

19 Q. What does OARRS have to do with the
20 abuse of prescription drugs and, in particular,
21 opioids?

22 A. Well, again this was a conference
23 by physicians for physicians. So we wanted to
24 make sure, even though the law had not required
25 it yet, we wanted to make sure physicians knew

1 this was a tool to help prevent doctor shopping
2 and, if you will, accidental even,
3 overprescribing.

4 If I prescribe, but he just got
5 some, that would be, kind of, an accidental
6 overprescribing of what the substance was. So
7 where it was an educational moment for the
8 doctors.

9 Q. Was the Summit County ADM Board
10 advocating for the passage of requirements in
11 the medical community to use the OARRS database
12 in connection with prescribing opioid
13 medications?

14 MS. KEARSE: Object to form.

15 A. We certainly were in favor of it.
16 I don't know whether there was a subcomponent
17 of our task force, because we had a separate --
18 an advocacy and policy component. They may
19 very well have been advocating. I don't recall
20 if they officially did.

21 Q. In what ways did the OARRS
22 database, if at all, relate to accidental
23 overprescribing?

24 MR. KEARSE: Object to form.

25 A. So it would help a physician make

1 certain that he or she was not giving some, you
2 know, say, a 30-day of supply of something to a
3 patient that they actually just got from
4 another doctor that, by the way, they didn't
5 happen to tell this doctor that they got.

6 So it would avoid getting more
7 pills than is needed medically.

8 Q. Okay. When did it become a
9 requirement in Ohio that physicians use the
10 OARRS database?

11 A. I believe officially required was
12 something like April 1 of 2015.

13 Q. All right. The next speaker is
14 somebody by the name of Gregory Boehm, who must
15 be a distinguished fellow, as he shares my last
16 name. Tell me about Dr. Boehm.

17 A. So he is actually somebody Dr.
18 Thrasher knew and recruited, but he works with
19 adolescents and addiction, also through
20 Recovery Resources, which is a treatment agency
21 up in the Cleveland area. It actually recently
22 merged with MetroHealth.

23 Q. Okay. Is he respected in the
24 medical community?

25 A. That's my understanding, yes. I

1 actually had not met him before or since that
2 day, but I met him that day.

3 Q. Do you know Dr. Samer Narouze, who
4 is down there at the 1:45 speaking slot on the
5 agenda?

6 A. Right. So I met him that day.
7 Another person -- again, a lot of these are
8 addiction people, and if they are not directly
9 at one of our agencies, I wouldn't know them.

10 But, yeah, he came as very highly
11 respected, and came and spoke about chronic
12 pain, because they have a chronic pain
13 specialty at the Western Reserve Hospital,
14 which used to be part of Summa, but is no
15 longer part of Summa.

16 Q. His presentation was entitled Best
17 Practices in Managing Chronic Pain, right?

18 A. Correct.

19 Q. Do you recall what he had to say
20 about that subject?

21 A. Not in any detail. His goal was to
22 talk about, okay, if you want to avoid
23 addiction, but you still need to treat pain,
24 here is how he recommended people go about it,
25 but I don't recall exactly what he said in

1 detail.

2 Q. Do you know if Dr. Narouze
3 prescribes or prescribed opioid medications?

4 A. I'm certain he does, does or did.

5 Q. Do you know anything about Dr.
6 Narouze's view on appropriate prescribing
7 guidelines for opioid medications?

8 MS. KEARSE: Object to form.

9 A. I don't know specifically what his
10 thoughts are.

11 Q. You said that you first learned
12 about opioids while you were in medical school,
13 right?

14 A. Certainly.

15 Q. And you said that you learned then
16 that opioids have addictive properties?

17 A. Yes.

18 Q. Fair to say you would be surprised
19 if there is a doctor out there who doesn't know
20 about that?

21 MR. KEARSE: Object to form.

22 A. Yes.

23 Q. But not everybody who uses an
24 opioid becomes an addict, correct?

25 MR. KEARSE: Object to form.

1 A. That's correct.

2 Q. In fact, overwhelmingly, people
3 don't become addicts just because they use an
4 opioid, true?

5 A. Well, my understanding, there is
6 like a dose frequency response curve, that if
7 you take them long enough, you will certainly
8 develop tolerance, that would happen to
9 anybody's brain, and that that increases the
10 likelihood that somebody will develop an actual
11 addiction.

12 Q. My question to you is, isn't true
13 that most people who use an opioid do not
14 become an addict?

15 MR. KEARSE: Object to form.

16 Q. Do you agree with that?

17 A. I'm thinking of whether I have seen
18 statistics, but, I guess, yeah, probably not.
19 It's certainly not 50 percent or more. So I
20 would say you're correct.

21 Q. You don't know what the percentage
22 is?

23 A. I do not.

24 Q. Why do some individuals who use
25 substances with addictive properties become

1 addicted, while most people don't?

2 MR. KEARSE: Object to form.

3 A. So my understanding is that, you
4 know, any of us have -- we all have a reward
5 system in our brain, and for some of us, we're
6 fortunate that reward system is turned on by
7 reading or streaming Netflix or riding a
8 bicycle or what have you, but there are some
9 people whose reward system gets particularly
10 turned on by certain substances.

11 So that might be an opiate, for
12 some people that might be alcohol, some
13 unfortunate individuals it might be both, and
14 those individuals, once their brain has been
15 rewarded through that pathway, they want more
16 of it, and then they will do things to get more
17 of it.

18 Q. Why would one person's brain
19 respond differently than another person,
20 exposed to the same substance? What is the
21 science behind that?

22 A. Genetic variation amongst brains.
23 Some people have a genetic predisposition, and,
24 again, I think some of that is, you know, maybe
25 there are certain people where their first dose

1 turns on the reward system so much, that they
2 are maybe automatically addicted. They now
3 have that disease.

4 There might be others who had to
5 take it for weeks or months and, within that
6 time period, it turned it on and off, they
7 developed it.

8 Q. Is it true -- well, let me back up.
9 Are you a specialist in addiction
10 medicine?

11 A. That depends on how you define
12 that.

13 Q. Okay. Well, let's be more
14 specific. Can somebody become board certified
15 in addiction medicine?

16 A. Yes, I believe they can now.

17 Q. Are you board certified in
18 addiction medicine?

19 A. I am not.

20 Q. Would you hold yourself out to the
21 medical community as a specialist in addiction
22 medicine?

23 A. No.

24 Q. Do you know enough to talk and to
25 express opinions about what are the root causes

1 of addiction? For example, you mentioned
2 genetic predisposition.

3 A. So I can talk about genetic
4 predisposition and about the brain and the
5 reward pathway. I don't know that science has
6 determined exactly who may or may not get
7 addicted. We certainly can't do a blood test
8 and predict that she would but she wouldn't,
9 for example. So I don't think there is anybody
10 who has that expertise.

11 Q. So it's complicated from a
12 prescriber's perspective, without having a
13 blood test, to know exactly who is going to
14 have the brain that gets turned on, versus who
15 is going to have the brain that doesn't?

16 MR. KEARSE: Object to form.

17 A. Correct. We can go through
18 clinical information. We expect physicians to
19 ask about family history about addiction,
20 because we do get our genes from our relatives,
21 from our parents, so we would try to screen for
22 it that way.

23 And if somebody has had an
24 addiction to one substance, we would be more
25 careful. They might be able to become addicted

1 to another substance.

2 Q. So if I understand you correctly, a
3 healthcare provider who is looking face-to-face
4 with a patient, trying to render a medical
5 judgment, has the advantage of being able to
6 examine that individual, ask questions of that
7 individual, and better inform their prescribing
8 decision; is that fair?

9 MR. KEARSE: Object to form.

10 A. Yeah. There is a doctor-patient
11 discussion to determine risks.

12 Q. But that process will not perfectly
13 predict outcomes, correct?

14 A. Correct.

15 Q. That's impossible?

16 MR. KEARSE: Object to form.

17 A. Yeah. Medical science doesn't have
18 an exact test yet.

19 Q. Now, just to go back quickly on the
20 question of addiction science. You're not
21 board certified in it. Have you ever received
22 any specific training in addiction medicine?

23 A. I mean, in residency, I did
24 rotations in addiction. So certainly I treated
25 many individuals on one particular unit,

1 inpatient unit, and some outpatients for their
2 addiction.

3 Q. What about outside of your
4 residency?

5 A. And then what I have learned
6 through my role at ADM, as well as attending
7 the various conferences, including the American
8 Academy of Addiction Psychiatrists.

9 Q. You described some of these doctors
10 who presented at your May 2014 conference as
11 addiction specialists?

12 A. Yes.

13 Q. You said many of them were
14 addiction specialists, right?

15 A. That's correct.

16 Q. So what would distinguish a doctor
17 like that, who you would call an addiction
18 specialist, from a doctor like you, who may
19 have some experience with addiction, but it's
20 not your area of specialty?

21 MS. KEARSE: Object to form.

22 A. So there is two routes to that.
23 One would be that they would go through an
24 actual fellowship, such as one that Dr. Delos
25 Reyes runs, and they would actually learn all

1 about addiction prevention, treatment, and so
2 forth.

3 The other route would be that they
4 ended up in a job where they are spending a lot
5 of time treating people with addiction, and
6 over time they would certainly be seen as
7 experts.

8 Q. Are there some individuals whose
9 brain is predisposed to be a addict, kind of
10 based on a lot of -- let me start that question
11 over, see if I can explain this idea right to
12 you.

13 Are there some --

14 MS. KEARSE: A question.

15 MR. BOEHM: What's that?

16 MR. KEARSE: Hopefully, there is a
17 question.

18 MR. BOEHM: Well, I hope not to be
19 able to disappoint you today.

20 Q. Dr. Smith, are there some people
21 whose brain is, kind of, predisposed to
22 addiction, across a variety of substances?

23 MR. KEARSE: Object to form.

24 Q. Does that question make sense to
25 you?

1 A. Yeah. There are certainly people
2 who seem to become addicted more readily to a
3 wide array of substances, yes.

4 Q. Is that more common than not, when
5 you are talking about addicts?

6 MR. KEARSE: Object to form.

7 A. Many of the people that we've --
8 that I am told about in our system are coming
9 in for one particular addiction, but, yes,
10 there is -- as we expand the availability of
11 marijuana, that's adding to the mix, so you are
12 finding more people.

13 Are they actually addicted?
14 Perhaps not, but there may be polysubstance
15 use, even though the person may actually have
16 the disease of addiction to one of the
17 chemicals.

18 Q. What do you mean by "polysubstance
19 use"?

20 A. We use the phrase when somebody
21 comes in for treatment, and we learn that they
22 are using marijuana and cocaine and opiates and
23 what have you. So they would be using more
24 than one potentially addictive substance, but
25 many times, if they are coming in for

1 treatment, they are really coming in for one
2 particular diagnosable use disorder.

3 Q. Why is that? If they are using
4 many different addictive substances, why would
5 it be that they are coming in to treatment for
6 only one of those substances; why wouldn't they
7 be getting treatment for more than one?

8 MR. KEARSE: Object to form.

9 A. So a disease of addiction means
10 that you spend your time either using the
11 substance, obtaining the substance, or thinking
12 about obtaining the substance, and then all the
13 behaviors that come from that, such as selling
14 your parents' TV set to get the money to buy
15 the drugs.

16 So that's the disease of addiction,
17 where basically the addicted part of your
18 brain, the animal part of your brain, is
19 fooling the thought -- thinking -- the one we
20 are all using today a lot, the thinking part of
21 our brain, and making it believe that these
22 behaviors are necessary, although not their
23 usual behavior.

24 So that would be addiction.
25 Somebody might use marijuana twice a week, in

1 quotes, recreationally, and it doesn't trigger
2 their reward system to lead to the addiction as
3 an illness. But they might have taken
4 Percocet, and their brain got turned on by
5 that, and they are actually actively addicted,
6 that is, doing all those behaviors. That would
7 be the difference.

8 Q. Is it common for addicts to be
9 using multiple addictive substances at the same
10 time?

11 MR. KEARSE: Object to form.

12 A. I'd say, yeah. It's not rare,
13 sure.

14 Q. And is there some medical
15 explanation for that?

16 A. A lot of people don't like, you
17 know, how they -- maybe they use a substance,
18 because they are addicted to it, maybe it gives
19 them a side effect they don't like. They may
20 look for something else to get rid of the side
21 fact, which might, of course, since they are
22 already buying drugs, often illegally, then
23 might be something else they buy on the street.
24 There is lots of theories behind it.

25 Q. Okay. From a forensic perspective,

1 or a statistical perspective, would you be able
2 to see a list of substances that somebody was
3 using and make a determination as to which
4 substance, in particular, the person was
5 addicted to, or is that something you would
6 need to determine based on a clinical
7 relationship?

8 MS. KEARSE: Object to form.

9 A. I would need some sort of data that
10 would lead me to that conclusion, such as
11 multiple admissions for that particular use
12 disorder, or I would need that relationship. A
13 list alone would not tell me the answer.

14 Q. Would not tell you what substance
15 was the one that person was addicted to?

16 MS. KEARSE: Object to form.

17 A. Correct. There are some medical
18 record systems where you put in -- whatever you
19 put in first is what they are there for, so you
20 might argue that, but that's not uniform.

21 Q. Just reviewing the documents, Dr.
22 Smith, it appears to us that one of the things
23 that the Summit County ADM Board has undertaken
24 to do is to identify the root causes of opiate
25 addiction and its impact in Summit County; is

1 that fair?

2 MR. KEARSE: Object to form.

3 A. What do you mean by "root causes"?

4 Q. Well, there has been some reference
5 to something called an opioid epidemic, right?

6 A. Correct.

7 Q. And that's something -- a term that
8 you've used?

9 A. Correct.

10 Q. So when I talk about the ADM
11 Board's efforts to try and understand the root
12 causes, I'm talking about the board's efforts
13 to try and understand what has caused this
14 level of opioid abuse that sometimes gets
15 referred to as an epidemic; does that make
16 sense?

17 A. Yeah, that's correct. Epidemic is
18 used as a technical term, because the
19 statistics, as done by epidemiologists, show
20 that it is an epidemic, based on how we define
21 epidemics. It's not just a word I'm using. It
22 is actually a technical term, because it
23 reached that level.

24 Q. Okay. But my question is slightly
25 different. I'm just confirming that one of the

1 things that the Summit County ADM Board has
2 undertaken to do is to try and identify the
3 causes of this opioid epidemic and its impact
4 specifically here in Summit County; is that
5 correct?

6 MS. KEARSE: Object to form.

7 A. Yes.

8 Q. And is it fair to say that the ADM
9 Board has summarized those findings and
10 conclusions and presented those findings and
11 conclusions to the community here in Summit
12 County?

13 A. Yes.

14 Q. What are we at, 9?

15 A. Yes.

16 - - - - -

17 (Thereupon, Deposition Exhibit 9, A
18 Document From the Summit County
19 Opiate Task Force, Beginning with
20 Bates Label SUMMIT 821280, was
21 marked for purposes of
22 identification.)

23 - - - - -

24 Q. You are looking right now at a
25 document, Dr. Smith, that has been marked as

1 Exhibit 9, for purposes of your deposition. It
2 is a document from the Summit County Opiate
3 Task Force; do you see that?

4 A. Yes, I do.

5 Q. What is the Summit County Opiate
6 Task Force?

7 A. So starting in -- well, we planned
8 it in 2013, but in early 2014, we launched the
9 opiate task force.

10 This was to -- as we determined how
11 difficult it was going to be to, we call it,
12 fight the opioid epidemic, we realized it was
13 going to take a village, as they say or, in
14 this case, a whole county.

15 So we pulled together the task
16 force. The task force started with four, now
17 has six subcommittees, and the goal of the task
18 force was to work on every possible avenue, to
19 decrease needless deaths from opiate overdoses.

20 Q. You indicated that -- I think you
21 said "we" set this up. Did you mean that the
22 ADM Board for Summit County is the entity that
23 set up the Summit County Opiate Task Force?

24 A. Correct. We are the ones who
25 initially planned it and launched it, yes.

1 Q. Does the Summit County Opiate Task
2 Force have its own leadership?

3 A. Our goal was to make it a truly
4 fully community-held entity. In practice, we
5 tend to -- ADM tends to orchestrate all of the
6 quarterly meetings and, through that mechanism,
7 you could say, provide some leadership, but
8 each of the subcommittees have their own
9 leaders, drawn from community, and, you know,
10 we don't tell them what to do. So they are
11 their own leadership.

12 Q. What are the subcommittees for the
13 task force?

14 A. So we have a -- no surprise -- a
15 healthcare subcommittee. Dr. Thrasher is
16 actually one of the cochairs of that, along
17 with Dana Nelson, who is at Akron Children's.
18 I will not know all the chairs. I know that
19 one.

20 We have a criminal justice
21 subcommittee, for law enforcement and judges
22 and so forth, to figure out what angle their
23 branches of government can bring to bear. We
24 have a policy and advocacy subcommittee. They
25 work with legislators. Both state and federal

1 have come to our task force at times.

2 We have an youth subcommittee.

3 That was a sad but kind of enlightening thing.

4 When we started the task force, we use to be at
5 4:00 in the afternoon, and we suddenly had
6 these young women showing up. It turned out
7 they had lost their brothers to opiate
8 overdoses, and they wanted to do something
9 about it. So we then had to create -- we moved
10 our meetings -- I'm sorry.

11 We used to have it in the morning.
12 We moved to the afternoon so they could come
13 after school. So the youth subcommittee has
14 been very, very strong.

15 How many did I list?

16 Q. You said healthcare, criminal
17 justice, policy and advocacy, and youth. So
18 you have identified four subcommittees.

19 A. Okay. I would have to look at a
20 document to remember every single one of them,
21 but...

22 Q. No others come to mind right now?

23 A. I do most of my work with criminal
24 justice and healthcare, so...

25 Yeah, I don't recall the other two.

1 I'll have to -- I'm sure it will be in a
2 document somewhere.

3 Q. That's okay. Do you know who runs
4 the task force? Who is the head of the task
5 force?

6 A. So from a leadership perspective,
7 ADM really has taken the leadership. We have
8 in recent -- in the recent year, I think, we
9 have hired a woman name Chyna Darrington to be
10 our lead of the Opiate Task Force. So she is
11 now --

12 Q. What's the name again?

13 A. Chyna, it's C-H-Y-N-A, Darrington,
14 I think it's D-A-R-R-I-N-G-T-O-N. So she has
15 been our -- relatively new, but she has come in
16 as the leader, to help coordinate the meetings
17 and so forth.

18 Q. When was she hired?

19 A. I believe this year.

20 Q. Was there somebody who had her
21 responsibility before she was hired?

22 A. No. It was Phil and us at ADM.

23 Q. Who at ADM was leading that charge?

24 A. Well, when Jerry quit, Craig would
25 be the one who would usually chair the big

1 quarterly meeting. Either myself or Eric
2 Hutzell would, kind of, go over the data
3 dashboard, kind of, how the metrics were going,
4 and then we would have other people come
5 present from each of the task forces. So
6 again, they are their own leadership. No one
7 is telling them what to do.

8 Q. You mean from each of the
9 subcommittees?

10 A. Yeah, subcommittees, yes.

11 Yes, so there was no one person who
12 could dedicate his or her time, and that's, we
13 felt, that was important, so...

14 Q. Okay. Based on this document that
15 I've marked as Exhibit 9 and that is in front
16 of you now, it appears that one of the things
17 the task force has done in Summit County is to
18 present findings about the opioid epidemic to
19 the broader community; is that fair?

20 A. Yes.

21 Q. This one looks like it was done in
22 Barberton?

23 A. Correct.

24 Q. Do you remember this particular
25 presentation?

1 A. Well, it's a document, but I don't.

2 Q. Is this similar, in form and
3 content, to other presentations made by the
4 task force to community members in Summit
5 County?

6 A. I mean, everybody uses their own.
7 Some use PowerPoint, some are using this. This
8 looks like it was somebody's script. It says,
9 "Thank you for the opportunity." So it looks
10 to me like somebody wrote this out so they
11 could follow along, as they gave a talk.

12 Q. Is this something that you would
13 have an opportunity to review, before an
14 individual went to make a presentation?

15 A. No.

16 Q. I say that, because this is
17 something that was produced to us from your
18 files. Do you know why a document like this
19 would be in your files?

20 A. Anything that's come up around
21 opiates, I have tried to collect it and keep it
22 and so forth. So I've got a lot of stuff in
23 the files.

24 Q. This document appears to reflect
25 the Summit County Task Force's conclusions in

1 it and, therefore, the ADM board's conclusions
2 about how the opioid epidemic happened. Do you
3 see the first question there, it's, "How did
4 this happen?"

5 A. Yes.

6 Q. And is that a fair characterization
7 of what we are looking at here on the first
8 page?

9 A. Yes.

10 Q. So the first thing on the list here
11 is marketing; do you see that?

12 A. Yes.

13 Q. Could you describe for us why you
14 think this had something to do with opioid
15 abuse in Summit County?

16 A. Sure. I mean, there is only two
17 countries in the entire world that allow
18 pharmaceutical companies to market their
19 medications directly to the enduser, us and New
20 Zealand. I'm sure that's why New Zealand is on
21 there.

22 And, as a result of that, Americans
23 are much more likely to become aware of the
24 medications, in this case the opiates.

25 Q. Are you talking about

1 direct-to-consumer advertising?

2 A. Yes.

3 Q. And in the United States,
4 direct-to-consumer advertising is legal and
5 permitted, under United States law, right?

6 A. That's correct. But we are only
7 one of two countries in the world that allows
8 that.

9 Q. And do you disagree with the laws
10 allowing direct-to-consumer advertising?

11 A. Well, based on the opiate epidemic,
12 I do now, yes.

13 Q. That's a decision that's made by
14 legislators, right?

15 A. That's correct.

16 Q. Have you yourself ever had direct
17 interaction with a representative of any
18 manufacturer of an opioid medication?

19 A. That's a good question. Again, I
20 don't prescribe them, so I don't tend to have
21 those reps. I certainly do psychiatric meds.

22 I think the only one would be an
23 anti-opiate medication. I've met with the
24 Alkermes, it's A-L-K-E-R-M-E-S, representative
25 about Vivitrol.

1 Q. You mean, like, an overdose
2 reversal type of medication?

3 A. Vivitrol is the injectable,
4 Naltrexone, so it actually is one of our
5 medications that we use for medication-assisted
6 treatment. So it's a blocker. It's an
7 antagonist.

8 Q. Okay. Also under this marketing
9 category there is a reference to a new
10 philosophy of pain management; do you see that?

11 A. Yes.

12 Q. What does that refer to?

13 A. Well, again, I haven't read this,
14 but I believe it goes hand to hand with the
15 physician piece, which is the concept that
16 perhaps pain was undertreated, and pain is a
17 vital sign, like pulse or respirations and,
18 therefore, you know, say prior, I don't know
19 the exact dates, I'll say 1995, because I'm
20 sure that's true, you know, prior to 1995, if
21 somebody sprained their ankle, they get rest,
22 ice, elevation, maybe Ibuprofen, a week later
23 maybe a heating pad.

24 The philosophy changed to where
25 suddenly people were getting particularly

1 Percocet and Vicodin, and I would think that
2 was a change in philosophy of pain management.

3 Q. When you talk about a change in
4 philosophy of pain management, who is adopting
5 this new philosophy; what are you talking about
6 in terms of this mindset?

7 MR. KEARSE: Object to form.

8 A. Well, I didn't write this, but I
9 believe -- I believe --

10 Q. Let's just pause there. I'm happy
11 to have you look at this, but I understand this
12 to be from the Opiate Task Force for Summit
13 County, and I understand that entity to be
14 under the direction and control of the ADM
15 Board.

16 So if there is anything in here
17 that you disagree with, in terms of your
18 physicians or you think mischaracterizes it,
19 then I would be happy to pause and let you look
20 at it, and you can let me know if that's the
21 case. Do you want to do that?

22 A. No. The point is if they write a
23 phrase, "A new philosophy," I don't know
24 exactly what the writer meant by that phrase.
25 I can describe to you what I believe has

1 happened with that, which is, again, we went
2 from my training, prior to 1995, that we should
3 be very careful about addictive substances of
4 all types that we could prescribe and,
5 therefore, not use them unless it was really
6 extreme.

7 So my training on opiates was
8 end-of-life pain, cancer pain, maybe a kidney
9 stone or childbirth, but it was not ankle
10 sprains, it was not low back pain.

11 And the change seemed to be, and I
12 don't know exactly all the parameters there,
13 but whether that really came from patients or
14 really came from some other forces, was that we
15 would start to give out addictive opiates to a
16 much broader group of people, and the net
17 result of that is you find more of those brains
18 that we never would have found under the old
19 model.

20 You would find more of those brains
21 that have a predisposition for addiction to
22 opiates, and you now end up with a bunch of
23 people addicted to opiates, who never would
24 have, and some of them died.

25 Q. I think, if I hear you right, you

1 are saying that prescribing practices of
2 healthcare providers shifted to prescribe
3 opioid medications more commonly than they
4 maybe would have sometime earlier; is that
5 right?

6 A. They shifted under pressure, yes.

7 Q. When you say "under pressure," what
8 do you mean?

9 Why do you think that physicians
10 changed the guidelines in terms of -- well, let
11 me actually back up and say it, I hope, better.

12 What do you think accounts for the
13 changing guidelines for increased prescribing
14 of prescription opioid medications?

15 A. So I believe somewhere around 2001,
16 I'm sure there was pressures from -- not from
17 physicians, prior to this, the Joint Commission
18 adopted, and they are the ones who accredit
19 hospitals and outpatient programs, including
20 the state psychiatric hospital I worked at for
21 years.

22 Joint Commission adapt -- I think
23 they were -- used to JCAH, and now they are
24 just the Joint Commission, they adopted pain as
25 the fifth vital sign, in the sense that they

1 incorporated it into standards.

2 So when they would come to survey,
3 including my own hospitals at the time, we were
4 required to do all -- jump through all sorts of
5 hoops, to make sure that a patient's pain was
6 managed, even though nobody was coming to our
7 hospital for pain, we would have to do that.

8 The net result was, there was a lot
9 of pressure, because you had to meet standards,
10 there was pressure on physicians to start
11 handing out Vicodin and Percocet in particular,
12 sometimes OxyContin, when we, otherwise, would
13 have been giving Ibuprofen and Tylenol, and
14 that definitely did not come from the
15 physicians.

16 Q. Well, you talked about this Joint
17 Commission. Can you tell us more about what
18 the Joint Commission is?

19 A. Yes. So they are a private entity,
20 although they're -- for many years now they
21 have been very connected to Centers for
22 Medicare and Medicaid. So I'm not sure how
23 private they are anymore.

24 But they go in, and they will
25 survey an outpatient setting or a hospital.

1 They have a huge list of standards, everything
2 from using separate cutting boards for your
3 meat and your vegetables, to how you address
4 pain, and everything in between.

5 So we are -- the hospitals -- it's
6 a badge of honor, basically, to be Joint
7 Commission accredited. No hospital wants to
8 not be Joint Commission accredited, and as a
9 result of that, hospitals work to comply with
10 these standards, even if they disagree with
11 them, even if they are in the background
12 pushing back on them, which I did, actually, at
13 Northcoast, before knowing there was an opioid
14 epidemic.

15 So we -- we were forced, in effect,
16 to start paying a lot of attention to pain and,
17 in effect, forced to start giving Percocet and
18 Vicodin and other things that we certainly
19 would not have been planning to give prior to
20 that.

21 Q. You talked about how the joint
22 commission adopted pain as a fifth vital sign;
23 did I hear you right?

24 A. That's correct, and that's in the
25 document.

1 Q. And what does that mean?

2 A. So they, and I don't know who they
3 was, somebody prior to Joint Commission created
4 this, I don't know who created it. They
5 brought the idea up, and Joint Commission
6 adopted it.

7 That concept was that it's so
8 important in a hospital to pay attention,
9 obviously, to your life vital signs. Pain is
10 equally as important, as a vital sign, as your
11 blood pressure. It is so important that you
12 must address it, just as if you would address
13 their heart rate being too slow or their blood
14 pressure being too low, i.e., really putting it
15 at a really high bar. This is like really,
16 really important, like, life requirements.

17 Even though physicians didn't agree
18 with that, I've heard many physicians say that,
19 number one, it's not a vital sign; number two,
20 the only way you can even wrap your mind around
21 it is that if you are in pain, you know you are
22 alive. So that, I guess, is a vital sign.
23 That's what I mean by that.

24 Q. How did that impact the way in
25 which prescription opioid medications were

1 being prescribed by healthcare providers?

2 A. I think it tremendously increased
3 the prescribing of opiates. And as you see on
4 the document, led to the United States, even
5 though we are not even 5 percent of the world's
6 population, using 99 percent of the world's
7 Vicodin. That's not happenstance. That is
8 clearly there was pressures to lead to that
9 problem.

10 Q. You indicated there was pressure on
11 physicians to prescribe more pain medications;
12 did I hear you right?

13 A. Yes.

14 Q. What did you mean by that?

15 A. Well, if you are told by the
16 leaders in your hospital or clinic that you
17 have to take pain as seriously as pulse, then
18 you are now going to do more and more and more
19 and more about that, which is what happened.

20 Add to that that some hospital
21 systems were actually then giving at least
22 partial -- partial reimbursement of physician
23 salaries, and I'm saying physicians, eventually
24 it was all prescribers, with nurse
25 practitioners, but partially your salary was

1 tied to your patient satisfaction scores.

2 So you have a lot of people coming
3 in with addiction, and you're saying, "No, my
4 clinical judgment is I'm not going to give you
5 any more Percocet," and they say, "Well, then
6 I'm going to downgrade you," suddenly you've
7 just hurt your own salary by doing what
8 clinically you believe is right, and over time,
9 human nature is you're going to just -- fine, I
10 want my money, like anybody else does, and
11 you're going to end up overprescribing, because
12 it's the only illness where patients are
13 basically now allowed to dictate the treatment
14 they get.

15 Q. Can you tell us more about these
16 patient satisfaction surveys; how did that
17 work?

18 A. So big ones, like -- even like
19 Press Ganey, basically, I would give, if I
20 treated -- let's say over the course of a
21 month, I treated everybody in this room. At
22 some point thereafter, you would be given the
23 opportunity to fill out a satisfaction survey.

24 The survey would ask questions
25 about your care, did you feel like you got the

1 right treatment, or maybe even the right
2 medications, depending on the survey, and, of
3 course, if this part of your brain is now being
4 tricked by your addicted brain, your illness,
5 well, now you're really pretty dissatisfied
6 that Dr. Smith wouldn't give you -- wouldn't
7 double your dose of Percocet.

8 So now I get a de- -- I get a low
9 report, and I get enough of those from people
10 with addictions, because again more people are
11 getting these drugs, more people are getting
12 addicted, now I get all these surveys saying,
13 "Hey, Dr. Smith's not a very good doctor," and
14 my pay gets cut, because the hospital tied my
15 pay to the survey, and human nature is, you're
16 not going to let that happen.

17 Over time you're going to be like,
18 you know what, all my colleagues seem to be
19 giving out Percocets like this, all the
20 patients are getting it, so I'm just going to
21 start doing it too.

22 And so the pressure was not only on
23 keeping your job, because you had to help the
24 hospitals and the clinics keep their Joint
25 Commission accreditation, it was also on your

1 salary.

2 So really for two reasons,
3 physicians were prescribing at a much higher
4 rate than certainly I was ever trained to do.

5 Q. Who was implementing these patient
6 satisfaction surveys that you referred to?

7 A. I don't know exactly all of them.
8 Press Ganey is the big one that you hear about.
9 The hospitals --

10 Q. Who was implementing them?

11 A. So hospitals do. Hospitals and
12 clinics, because it's about customer service.

13 So you -- you know, good business
14 practice is let's make sure we are keeping our
15 clients, customers, consumers, whatever you
16 want to use in your business, satisfied.

17 And so they started doing these
18 surveys, and some of them decided to tie part
19 of physicians' salaries, I guess some kind of a
20 weird version of value-based payment, to the
21 patient satisfaction surveys.

22 Q. Did any government entities or
23 medical organizations, other than the Joint
24 Commission, also adopt these standards designed
25 to address the problem of untreated or

1 undertreated pain?

2 MR. KEARSE: Object to form.

3 A. I honestly don't know. I don't
4 know how much the AMA got involved, I don't --
5 so I don't know whether there was another
6 component of this that got involved.

7 I know that the -- all the talk
8 amongst physicians that I was interacting with,
9 again mostly psychiatrists and primary care
10 doctors, was this sense of why is pain a vital
11 sign, why are we being told that we have to
12 make such a big deal about pain, because none
13 of us were trained that way.

14 Q. Okay. You're not aware of any
15 other entities in the medical community or
16 regulatory bodies also modifying prescribing
17 standards or guidelines, with an eye toward
18 ensuring that patients who are suffering from
19 debilitating pain received treatment for that
20 pain?

21 MS. KEARSE: Object to form.

22 Q. Other than the Joint Commission?

23 A. As I said, in my mind's eye, the
24 AMA might have done something, but sitting here
25 this moment, I don't recall.

1 Q. What about the VA?

2 A. I don't work for the VA.

3 Q. But I'm asking if you are aware of
4 that? I mean, you have looked into what you
5 understand to be the causes here, you have got
6 this document that describes what you
7 understand the causes to be. So that's what
8 I'm asking you about.

9 A. I wouldn't --

10 MR. KEARSE: Object to form.

11 A. Again, the VA probably isn't Joint
12 Commission accredited, but I wouldn't doubt
13 that they are having those very discussions.

14 Again CMS, which is also federal
15 government, very much working together with
16 Joint Commission more and more every year, I
17 think. So I wouldn't be surprised if the VA
18 would have also done some version of pain as a
19 vital sign and said we need to treat pain
20 better.

21 Q. Were there respected physicians in
22 academia who also were trying at this time to
23 highlight the importance of undertreated or
24 untreated pain?

25 A. I'm sure that was in the background

1 of all of this. No doubt that there must have
2 been some physicians. Again, at this point,
3 I'm jaded by all this. So, you know, some of
4 them probably were paid speakers by Pharma to
5 go around and talk about the wonders of
6 OxyContin, for example.

7 So I don't know how much they could
8 have been -- they usually are really well
9 respected people, and they might have really
10 believed what they were saying, but I think
11 that would also be another pressure on
12 physicians, in general, to say, "Oh, well, if
13 Dr. Jones said that, it must be okay to start
14 using it."

15 So it is another reason we would
16 start giving out more opiates that we otherwise
17 wouldn't have, just using our prior clinical
18 judgment.

19 Q. You said that at this point you are
20 jaded by this, and I think what you mean, and
21 tell me if I'm wrong, is that at this point you
22 are looking back in time, retrospectively, and
23 assessing statements that were made, in some
24 cases decades ago, about the problem of pain --

25 MS. KEARSE: Object to form.

1 Q. -- and treatment of pain; is that
2 right?

3 A. Well, I'm jaded because of so many
4 people that have died needlessly from this, and
5 seeing statistics such, wow, look how many
6 opiates we use in this country compared to any
7 other country, clearly something went wrong.

8 Q. I understand that. I'm trying to
9 ask a slightly differently question.

10 You talked about -- I've asked you
11 about medical organizations, regulatory bodies,
12 specific respected physicians in academia and
13 in private practice who were trying to address
14 the issue that they thought was important at
15 the time, undertreatment and untreated pain.

16 And my question for you is, do you
17 think that those people were being dishonest or
18 disingenuous or were throwing away their
19 good-faith medical judgment for pecuniary gain?

20 MR. KEARSE: Object to form.

21 A. No. As I said -- I did say, I
22 don't doubt that they believed what they were
23 saying at the time. It just clearly was wrong.

24 Q. In hindsight, you're saying what
25 those people were saying then, you don't

1 believe is correct, but you are not suggesting
2 that they had ill will or that they were
3 favoring money over the safety of their
4 patients?

5 MR. KEARSE: Object to form.

6 Q. I mean, if you disagree with that,
7 just tell me. I just want to know what your
8 opinion is.

9 A. I do think -- I think there has
10 been a big exposé on this in recent years, that
11 there were -- there are some physicians,
12 historically, and it's much harder now, who
13 did, in fact, take a lot of Pharma payments to
14 promote -- help promote certain medications
15 that, yes, they were choosing money over
16 ethics.

17 Q. Are you aware of any particular
18 doctors who you think -- now, let me give you
19 an example. You have been paid, right, by
20 lawyers to give testimony in cases, right?

21 A. That's correct.

22 Q. Right. And you are paid \$400 a
23 lawyer for that, right?

24 A. Most recently, yes.

25 Q. When you do that, do you throw out

1 your own independent medical judgment because
2 you're being paid \$400 an hour to offer
3 opinions?

4 MR. KEARSE: Object to form.

5 A. No. There is a big difference
6 though. I'm paid for my time, not my opinions.
7 So I often am retained to review a case, and
8 you know what, my opinion doesn't favor the
9 person that hired me. They still pay me, and
10 it just doesn't go forward to trial, or what
11 have you, with me. Sometimes nobody even knows
12 I existed, because of the discovery rules.

13 So that's different than, doctor,
14 go out and lecture, because we're going to
15 watch you do it, and, by the way, we are going
16 to pay you X amount to say great things. Not
17 only that, we are going to give you the slide
18 set, and you can't deviate from the slide set,
19 because that's what we want you to say, which
20 is what Pharma does.

21 I did one of those lectures, years
22 ago, for Risperidone, a long, long time ago,
23 and I didn't like it at all. It was canned,
24 and I couldn't go off script, so to speak.

25 Yes, I believe there have been

1 physicians, and I think we have seen exposés
2 about that, where they made over \$100,000
3 giving talks about something that, it's a
4 little hard to believe, that they all believed
5 everything they said in those canned
6 transcripts.

7 Q. Are there particular physicians who
8 you want to identify, who you think have -- who
9 have thrown out their clinical judgment for
10 pecuniary gain?

11 A. No. I don't know any personally.

12 Q. You are not aware of any specific
13 instances of that, right?

14 A. Correct.

15 Q. You indicated that when you were at
16 Northcoast, did I hear you say that you, kind
17 of, pushed back on the prescribing of opioids?

18 A. I pushed back on the need for us to
19 emphasize pain for every patient coming into
20 the hospital. We had myriad discussions, and
21 even talked to Chicago, to the Joint
22 Commission, and CMS actually at one point, to
23 say, can we not do this as part of the
24 standards, that this was a -- my fear, quite
25 frankly, part of the time was addiction.

1 And this is not our business. This
2 is not what we are doing. We've got primary
3 care doctors, psychiatrists. We don't have a
4 pain specialist on staff. Why are we being
5 told -- I mean, we were told, through this
6 process, if they couldn't answer your question
7 about pain, we had to show them little grimace
8 faces and smiley faces, the FLACC scale, and
9 try to get a sense of their pain that way.

10 Just way different than the rest of
11 the kind of care they were trying to provide to
12 people with psychosis and depression and mania.
13 It just didn't make any sense that we were
14 being required to focus on pain.

15 Q. If I understood your testimony
16 earlier, at Northcoast, the psychiatric
17 hospital, it was very infrequent that people
18 showed up with --

19 A. It was.

20 Q. -- with opioid prescriptions,
21 right?

22 A. Correct.

23 Q. And, in fact, I thought I heard you
24 testify that in all of those instances, those
25 individuals showed up with already having been

1 prescribed opioids; did I understand that
2 correctly?

3 A. That's correct.

4 Q. Okay. So when you talk about
5 pressure at Northcoast on physicians to
6 prescribe opioids, how does that match up with
7 what you testified to earlier?

8 MR. KEARSE: Object to form.

9 A. I didn't say pressure to prescribe
10 opioids. I said pressure to deal with pain as
11 such a big issue.

12 So we still did have to ask every
13 patient about pain, give every patient a pain
14 scale on some regular basis, nurses had to be
15 burdened to go check with the patients on a
16 frequent basis about pain. So it really did
17 add a layer that just didn't -- it took away
18 time for the more important things we were
19 there to treat.

20 Q. I see. So when you talk about
21 pushing back, you're talking about the effort
22 to pay attention to patients' pain, maybe more
23 than you otherwise would have, not really the
24 use of prescription opioid medications, right?

25 MR. KEARSE: Object to form.

1 A. Correct.

2 Q. Are you aware --

3 MR. BOEHM: I'm almost done. We
4 can go to lunch.

5 MS. KEARSE: Yeah. I think the
6 court reporter --

7 Q. Are you aware of any specific
8 instances in Summit County where healthcare
9 providers, you believe, chose their own salary,
10 some financial benefit over making a decision
11 that was, in their view, at that time,
12 clinically appropriate for the patients that
13 they were treating?

14 MR. KEARSE: Object to form.

15 A. I am not, but again, in my role, I
16 wouldn't just stumble -- I wouldn't find that,
17 unless probably it was in the newspaper. So it
18 wouldn't be something that I would, like,
19 happen upon, you know, in my chart reviews or
20 something. So, no, I'm not aware.

21 Q. And in your efforts to try and
22 understand opioid abuse, the level of opioid
23 abuse, the causes of the opioid epidemic in
24 Summit County, you are not aware of any
25 instance where you believe the healthcare

1 provider sacrificed, what was in his view, his
2 or her view, what was appropriate for a
3 particular patient, in favor of more money?

4 A. I'm not.

5 MR. BOEHM: I think we can take a
6 break and maybe go to lunch.

7 THE VIDEOGRAPHER: Off the record,
8 12:32.

9 (Recess taken.)

10 THE VIDEOGRAPHER: We are back on
11 the record, 1:46.

12 Q. I hope you had a nice lunch, Dr.
13 Smith.

14 A. Yes, thank you.

15 Q. Welcome back.

16 When we broke, we were looking at
17 this document that's been marked as Exhibit
18 9 --

19 A. Yes.

20 Q. -- from the Opiate Task Force for
21 Summit County, and we were going through some
22 of the information listed here; do you recall
23 that?

24 A. Yes.

25 Q. I want to direct your attention to

1 the section with the Physicians heading. It is
2 in the middle of the first page.

3 A. Okay.

4 Q. Do you see that?

5 The final bullet point says,
6 "Accrediting bodies have addressed pain relief
7 in their standards, again affecting
8 reimbursement"; what does that mean?

9 A. So similar, that's probably,
10 mostly, the Joint Commission, as an accrediting
11 body. So again, if you're not -- if you're not
12 complying with the standard, then whoever is
13 employing the physician is not going to be
14 happy, so your job is potentially on the line,
15 if you don't comply, and that standard really
16 pushes physicians to prescribe more narcotic
17 pain meds.

18 Q. Okay. When it talks about
19 accrediting bodies, in the plural, are there
20 other accrediting bodies that you are aware of,
21 other than the Joint Commission, that addressed
22 pain relief in their prescribing guidelines and
23 standards?

24 A. Well, CS -- so Centers for Medicaid
25 and Medicare, and I may have those two

1 reversed, but anyway, CMS, they do so much with
2 drug commission, they may well have. I don't
3 know if they are exactly in that -- in their
4 conditions of participation or not, but they
5 may have.

6 Q. What does it mean here, where it
7 refers to the effect on reimbursement?

8 A. Well, so if -- the CMS is about
9 money, Joint Commission is not, but if Joint
10 Commission has a negative finding, then they
11 usually report it to CMS, who then comes and
12 reviews, and if you're not meeting standards,
13 then they will pull money, so CMS would
14 literally reimburse less, which means now
15 someone is angry at the doctor. Again, it's a
16 vicious cycle.

17 Q. Is the Joint Commission led by
18 individuals with medical and scientific
19 expertise?

20 A. My understanding is they do have
21 some physicians, I think. I don't know if he's
22 still there, I think there was a doctor, maybe
23 Mark Chassin, who was the executive director at
24 some point, but they do have -- certainly have
25 physicians, and their surveying team usually

1 includes at least one physician, and then
2 nurses and social workers who come out, and
3 environment people, who understand code and so
4 forth, to make sure you have a safe
5 environment.

6 Q. Do you know anything about the
7 processes by which the Joint Commission
8 establishes prescribing standards and
9 guidelines?

10 A. I do not.

11 Q. Do you have any reason to believe
12 that the Joint Commission, in establishing
13 guidelines with respect to opioids and opioid
14 prescribing practices, failed to exercise what,
15 at the time, those individuals believed to be
16 their best clinical judgment about what was
17 appropriate?

18 MR. KEARSE: Object to form.

19 A. Can you repeat that, please?

20 Q. I'm hoping it's good enough just to
21 have the court reporter read back to you, and I
22 can rephrase it if it doesn't make sense after
23 that.

24 THE NOTARY: Question: "Do you
25 have any reason to believe that the Joint

1 Commission, in establishing guidelines with
2 respect to opioids and opioid prescribing
3 practices, failed to exercise what, at the
4 time, those individuals believed to be their
5 best clinical judgment about what was
6 appropriate?"

7 A. No. I have no -- no way of
8 questioning that.

9 Q. Okay. You can set that document
10 aside.

11 Actually, before you do that, you
12 don't even need to turn back it to, but you
13 notice that document used the term "epidemic."
14 We talked about that.

15 A. Yes.

16 Q. And you had mentioned, in your
17 testimony earlier, that there is an
18 epidemiological definition or standard for the
19 term "epidemic"?

20 A. Yes.

21 Q. What were you referring to?

22 A. So epidemiologists have the role of
23 watching data trends. If a bunch of people get
24 sick, they go and investigate, and they may
25 discover that was E. coli in Chipotle lettuce,

1 for example. That's how that all works.

2 So with this epidemic, they look at
3 metrics, the math, the numbers of people
4 affected, the deaths, and you can determine --
5 and I don't know the exact cutoff, but they do
6 determine then whether something is officially
7 epidemic.

8 There is a Dr. Li, L-I, at Columbia
9 University, who is very well respected in this,
10 and he looked at this and compared it even to
11 epidemics like the 1918 flu epidemic that
12 killed so many people, and this meets all the
13 metrics, mathematically, that that epidemic
14 met.

15 Q. Okay. So your understanding is
16 that the term "epidemic" is, in scientific
17 terms, a statistical matter, it's a statistical
18 question, it's a term of art?

19 I'm going to strike all that. That
20 was a mess. I'm going to back up and start
21 over.

22 Is it fair to say that your
23 understanding of the term "epidemic," as used
24 in the scientific community, is that it has to
25 meet a particular defined scientific standard?

1 MR. KEARSE: Object to form.

2 A. Yes. I believe it's based on a
3 mathematical calculation, yes.

4 Q. Okay. You are not an
5 epidemiologist, I take it, correct?

6 A. I am not.

7 Q. So you yourself have not conducted
8 any kind of analysis to determine whether or
9 not anything, including opioid abuse, is an
10 epidemic; is that fair?

11 A. Right, I have not.

12 Q. When you talk about an opioid
13 epidemic, what outcome are you specifically
14 referring to, when you say epidemic?

15 A. So my understanding is the epidemic
16 is about the number of people dying, as it was
17 in the 1918 flu epidemic.

18 It's about you got X number of
19 people dieing in a certain timeframe by a
20 certain mechanism, and if it reaches a certain
21 mathematical threshold, again, I don't know
22 what that is, it can be defined as --
23 officially as an epidemic.

24 Q. Do you know in what year the
25 mathematical standards for calling something an

1 epidemic was met, in terms of opioid-related
2 deaths?

3 A. I don't know the exact year. I do
4 know that the first time I saw it published was
5 by Dr. Li in 2014, because I cringed when I
6 read it, because further, the mathematical
7 model predicted that the epidemic would not
8 peak until 2017, based on his math.

9 Q. I'm asking you a slightly different
10 question, not when did you read an article
11 about or even when an article was published.

12 My question to you is do you know
13 in what year, based on what mathematical
14 standards would be applied to determine whether
15 or not something meets the definition of an
16 epidemic, that would be the case with respect
17 to opioid-related deaths?

18 MR. KEARSE: Object to form.

19 A. I don't know the year.

20 Q. Okay. I think we are at Exhibit
21 Number 10.

22 - - - - -

23 (Thereupon, Deposition Exhibit 10,
24 Email Exchange From February 2014,
25 Beginning with Bates Label SUMMIT

1 105557, was marked for purposes of
2 identification.)

3 - - - - -

4 Q. Which I'm going to give to you now.
5 Exhibit 10, Dr. Smith, is an email
6 exchange from February 2014 that starts with a
7 February 21 email from you; do you see that?

8 A. Yes.

9 Q. And it appears that this February
10 2014 email from you is an invitation to
11 individuals to attend the May 31, 2014
12 conference that you organized and that we
13 discussed earlier today; is that correct?

14 A. That's correct.

15 Q. And you write, if you look in the
16 middle of the page, "Clearly, the epidemic is
17 the result of many factors"; do you see that?

18 A. I see that.

19 Q. "And attempted resolutions will
20 require new laws, new public processes, and
21 changes in the behavior of both patients and
22 clinicians."

23 A. Yes.

24 Q. I read that correctly?

25 A. Yes.

1 Q. When you wrote that, "The epidemic
2 is the result of many factors," what epidemic
3 were you referring to in February of 2014?

4 A. The opioid epidemic.

5 Q. Referring to the number of
6 opioid-related deaths?

7 A. Yeah. You asked what epidemic, I
8 said the opioid epidemic.

9 Q. Right. And specifically, you are
10 talking about the number of opioid-related
11 deaths; is that correct?

12 A. Right. And I may have very well
13 read that article by then, yes.

14 Q. You say that that epidemic is the
15 result of many factors. What did you mean by
16 that?

17 A. That there is a bunch of reasons
18 that we ended up with an epidemic, including
19 things we've talked about today, the
20 direct-to-consumer marketing, the fact that
21 pain became such a focus that required
22 physicians to prescribe opiates at a much
23 higher rate than they would have previously and
24 so forth.

25 One of the other factors was the, I

1 guess, mischaracterization of OxyContin as not
2 being addictive because somehow it was a new
3 form, and, therefore, doctors could use it at
4 will, and that, of course, was false.

5 Q. When you talk about the
6 mischaracterization about OxyContin, can you be
7 more specific about what you are referring to?

8 A. Yes. My understanding is that the
9 makers of the drug were using an article, that
10 wasn't even a study, from, I forget, Dr. Jick,
11 or something like that, who had studied a few
12 of his own patients and decided that, oh, look,
13 very few of them get addicted, and that got
14 taken around the country, but with the
15 pharmaceutical representatives and others, and
16 it was another educational thing for
17 physicians, but it was not true, and it wasn't
18 a study either, and so that's another factor.

19 So now you've got physicians who
20 generally go into the profession to care for
21 people, you know, first do no harm is our big
22 issue. We really want to help people, and so
23 we believe we are helping people, oh, good,
24 I've got patients in pain, everyone is telling
25 me I've got to treat pain, here is a drug that

1 won't cause addiction, so I'm going to use this
2 drug, and it turned out to be just as
3 potentially addictive as other opiates and,
4 sadly, just as deadly.

5 Q. I am going to ask you to turn back
6 to Exhibit 9 after all, since you, kind of,
7 referred back to it.

8 As we discussed, this document
9 asked the question, "How did this happen?" at
10 the very top of the document; do you see that?

11 A. Yes.

12 Q. And then do you see what I take to
13 be the Summit County Opiate Task Force's answer
14 to that question, as laid out in these bullet
15 points; is that fair?

16 A. Yes.

17 MS. KEARSE: Objection. Form.

18 Q. And you referred to -- we've
19 discussed some of them, and I haven't discussed
20 every detail about each of them, but my
21 question for you right now is whether or not,
22 in reviewing this list, there are other factors
23 that you believe have materially played into
24 the opioid epidemic, in Summit County and
25 beyond Summit County, that are not identified

1 and discussed here on the first page of Exhibit
2 9.

3 A. Let's see. I have to look at this
4 and see if it is missing some of the ones that
5 we think about.

6 Q. Sure. Take your time.

7 A. Yeah. There is one here we haven't
8 discussed, which is under Marketing, the last
9 bullet point, "Perceived safety of prescription
10 drugs."

11 You know, so part of the problem is
12 that, if you go back in time again, I just use
13 1995 because it predates all this stuff, you
14 know, most physicians and the public, I expect
15 in general, had a sense that opiates were
16 dangerous.

17 The only thing most of the public
18 knew about opiates was the very different kind
19 of heroin problem that occurred way back in the
20 70s, kind of attributed to like
21 down-in-the-gutter kind of people, a very, very
22 different issue.

23 And now suddenly you are hearing
24 from your friends, your neighbors, your
25 physicians and others, and again

1 direct-to-consumer advertising and so forth,
2 oh, these drugs are fine, they are safe, you
3 have pain, you deserve your pain to be treated,
4 you know, more effectively, and so the
5 perception of the public becomes, oh, then they
6 must be safe, we are hearing about them all the
7 time, and the net result is then even patients
8 coming in with a sprained ankle asking for the
9 opiates now, because they are hearing about
10 these opiates. They never would have done in
11 that 1995. They were doing that. So that's
12 another factor we touched on that definitely
13 has an effect.

14 Q. Okay. Do you know of any
15 healthcare providers, who have prescribed
16 prescription opioid medicines, who did not know
17 that they had addictive properties?

18 A. No.

19 Q. Okay. Anything else that you think
20 is a material contributor to the opioid
21 epidemic that is not identified here in Exhibit
22 9?

23 A. No, not at the moment. This is
24 pretty comprehensive.

25 Q. The third category here is about

1 Diversion. Can you explain to us what
2 diversion is?

3 A. Sure. So diversion would be that
4 an individual gets their prescription of
5 whatever, in this case opiates, and they either
6 give it or sell it, some of that portion of
7 that, to somebody else who was not officially
8 prescribed that medication.

9 Q. All right. Let's go back to
10 Exhibit 10, where we were discussing you having
11 announced this May 2014 conference about opioid
12 abuse that you were organizing, right?

13 A. Yes.

14 Q. And a gentleman by the name of Nick
15 Jouriles, -- am I pronouncing that correctly?

16 A. Yes.

17 Q. Mr. Jouriles writes back to you
18 saying, "Blame TJC for regulating," quote,
19 "pain, the fifth vital sign and so modifying
20 physician behavior. Thanks"; do you see that?

21 A. Yes.

22 Q. Who is Mr. Jouriles?

23 A. Actually, Dr. Jouriles, he was the,
24 at the time, the head of the -- all of the
25 emergency departments for the Akron General

1 Hospital system, now Cleveland Clinic/Akron
2 General.

3 Q. Yeah. His email address says Akron
4 General. Does that mean he practices in Akron?

5 A. Oh, yes.

6 Q. Is he a well-respected physician in
7 the community?

8 A. Yeah. He wouldn't be the chair of
9 the department, if he wasn't. Yes.

10 Q. Do you know if Dr. Jouriles
11 prescribed or has prescribes opioid medicines?

12 A. As an emergency physician, I'm sure
13 he has.

14 Q. And Akron General Hospital has
15 prescribed and continues to prescribe opioid
16 medications to patients, correct?

17 A. I'm sure they must.

18 Q. What did you understand Dr.
19 Jouriles to be saying when he referred to the
20 fifth vital sign from TJC modifying physician
21 behavior?

22 A. I think it was short for what I
23 have described in more detail, the Joint
24 Commission. TJC, you know, took this -- I
25 don't think created, but took the fifth vital

1 sign and incorporated it into some pretty
2 stringent standards, and then modified
3 physician behavior, forcing us to prescribe
4 more opiates than we otherwise would have,
5 based on our purely unfettered clinical
6 judgment.

7 Q. When you say the doctors were
8 forced to prescribe more opioids, is that
9 the -- what do you mean by that?

10 Do you think that there were
11 doctors who were compelled or forced to
12 prescribe opioids?

13 MR. KEARSE: Object to form.

14 A. Yes. Certainly.

15 Q. How so?

16 A. Again, if you're working in a
17 system that is accredited by the Joint
18 Commission, which also probably means CMS, and
19 you don't follow the standards, and the
20 hospital gets a citation for not meeting the
21 pain standards, then that physician's practice
22 is in danger. So that's pretty forcing.

23 You are going to lose your job if
24 you don't, you know, go with the flow. They
25 probably have individuals at these big -- I'm

1 sure they do -- individuals in the systems who
2 go around and review charts, match the
3 standards, they look at Dr. Jones' chart, match
4 the standards, they look at Dr. Jones' chart,
5 and they are going to be all over Dr. Jones if
6 Dr. Jones is going to lose them that
7 accreditation.

8 So that's -- I would say the doctor
9 is going to be pretty well forced to either
10 resign or go with the flow. Well, you know,
11 human nature, doctors are humans as well, you
12 are probably going to try to go with the plan.

13 Q. Okay. And let me go back to a
14 question that, I think, we touched on earlier.

15 Are you aware of any specific
16 doctor, who you know of, who prescribed an
17 opioid to a patient against his or her best
18 clinical judgment because of concern about
19 money or concern about hospital administration
20 taking action against that physician?

21 MR. KEARSE: Object to form.

22 A. So I can't exactly recall names,
23 but at conferences and other situations, where
24 I was amongst physicians, where the topic of
25 opiate prescribing came up, many physicians

1 were complaining that they felt like they were
2 prescribing a lot more opiates than they would
3 have liked to prescribe, and the Joint
4 Commission, CMS, and patient satisfaction
5 scores were the main reasons they gave.

6 Q. Are you able to identify any
7 particular instance where, in your judgment or
8 to your knowledge, a specific physician made a
9 specific prescription of an opioid to a patient
10 when that physician believed it was not in that
11 patient's best medical -- in the interests of
12 that patient's best medical care?

13 A. No, I can't give that detail.

14 Q. You write in this email, on
15 February 21, 2014, that, "The epidemic is a
16 result of many factors, and its resolution will
17 require new laws, new public processes, and
18 changes in behavior of both patients and
19 clinicians."

20 When you refer to it requiring new
21 laws, what did you have in mind?

22 A. So there needed to be -- at that
23 point, it was so imbedded with Joint
24 Commission, so we really needed some laws about
25 pushing back on that, thus decrease the number

1 of pills we are giving out, let's decrease the
2 pressure on physicians, let's -- and that also
3 helps the public perception, because when they
4 hear, wait a minute, there is a problem, there
5 is so much of a problem that our government has
6 just made a law that says you are not going to
7 be able to get X amount of pills and that kind
8 of thing, so that's the kind of changes that
9 I'm referring to.

10 Q. Were there particular laws that you
11 had in mind here when you said that combatting
12 the opioid epidemic would require new
13 legislation?

14 A. I think I just answered that.

15 Q. Nothing else, no other particular
16 laws that you had in mind here?

17 A. Well, again, my purpose of this was
18 by physicians for physicians. So it was really
19 about helping the physicians get out from under
20 the burden of these kind of pressures.

21 There were -- I'm not sure if they
22 were in evidence yet or they were about to come
23 out, there were some prescribing guidelines
24 that were being -- if not created, had just
25 been created for the emergency room physicians,

1 and postings to post for the patients, so the
2 patients understood you're not going to walk
3 into this ER and just get as many pills as you
4 want, because there are new rules for the
5 doctors, as well as the patients.

6 So all of those kind of factors
7 were ways to help protect the -- and decrease
8 the overprescribing.

9 Q. Are you talking the OARRS database
10 requirements?

11 MR. KEARSE: Object to form.

12 A. No. Separate from that.

13 Q. Okay. I'm sorry. I'm probably
14 just being slow on the take here, but what is
15 the specific legislation that you thought
16 needed to be passed in 2014, that wasn't yet in
17 effect, to help combat the opioid epidemic?

18 A. So rules that would push back on
19 the vital sign requirements, that would allow
20 physicians to use their clinical judgment
21 without concern for Joint Commission or anybody
22 else making pain an erroneous fifth vital sign,
23 as one example.

24 Q. Do you have any other examples;
25 anything else that comes to mind?

1 A. I don't remember. We have had so
2 many laws passed that what wasn't then or what
3 needed to be, I'd be hard pressed to tell you
4 that.

5 Q. Okay. You next talk about new
6 public processes. What did you have in mind
7 with respect to new public processes?

8 A. A lot of that, that as well as the
9 behavior of patients, was about helping the
10 public understand addiction as an illness and
11 help get rid of stigma, so, like, patient
12 behavior could change, so they'd actually come
13 in to get help. A lot of people with addiction
14 still don't, even now, come in to get help.

15 Public processes, some of that is
16 because many people in the public, probably
17 less so now with the epidemic, but many people,
18 I suspect even some in this room, don't
19 necessarily understand addiction as a disease,
20 and that's -- that's damaging, because then
21 people are afraid to go get help, they don't
22 want their colleague to know they got help and
23 so forth. So that would be another change that
24 we would need to eventually -- still, I think,
25 need to accomplish.

1 Q. How do you do that through public
2 processes?

3 A. Education. Some laws can open up
4 doors to making it -- if you -- mental health
5 has a stigma. Addiction has a stigma. If I
6 said that as part of your -- whatever your
7 health plans are, ours is Med Mutual, that not
8 only is it an option for you to go get an
9 assessment for addiction, it's required, and
10 that became the norm over time, that would get
11 rid of the stigma. It would be a normal thing
12 to go in, and everybody gets an addiction
13 assessment.

14 You wouldn't be -- she wouldn't be
15 stigmatized to say to me, hey, I had my
16 assessment today, because it would be the norm.
17 So that would be another -- that would be a
18 huge public process, affecting all of
19 healthcare, for example.

20 Q. And this may lead into the next
21 category that you mentioned in your email,
22 which is, "Changes in both patients" --
23 sorry -- "Changes in the behavior of both
24 patients and clinicians."

25 What did you have in mind when you

1 talked about combatting the opioid epidemic
2 through changes in the behavior of both
3 patients and clinicians?

4 A. Sure. So the idea for -- I'll
5 start with patients, would be to help decrease
6 the barriers to getting access to care. One of
7 the biggest is stigma. And we want to help
8 them -- educate them enough so that people
9 would realize it is worth them changing their
10 behavior, getting in to get help, as opposed to
11 continuing to suffer in silence, many times.
12 Excuse me.

13 The clinicians, again it was more
14 about making sure they were educated so that
15 they could maybe have a better chance of
16 following their own clinical thought process,
17 as opposed to falling prey to a lot of these
18 other factors that were forcing and requiring
19 them to prescribe more opiates than they hoped,
20 than they would have in their own practices.

21 - - - - -

22 (Thereupon, Deposition Exhibit 11,
23 October 2016 Email Exchange Between
24 Smith, Craig, and Skoda, Beginning
25 with Bates Label SUMMIT 153786, was

1 marked for purposes of
2 identification.)

3 - - - - -

4 Q. I'm going to give you a document
5 that I've marked as Exhibit 11. It's an email
6 exchange that goes back to October of 2016
7 between you, Mr. Jerry Craig and Dr. Donna
8 Skoda; do you see that?

9 A. Yes.

10 Q. It appears that Dr. Skoda is
11 forwarding -- I'm sorry. Is she a doctor?
12 Maybe I'm mis- --

13 A. No, she's not.

14 Q. -- misdesignating her.
15 That Ms. Skoda is forwarding to you
16 a link to a DEA press release; do you see that?

17 A. I see it.

18 Q. She writes, "See the link below.
19 Amen"; do you see that?

20 A. I see that.

21 Q. And then you write back to her
22 saying that you recently told the board, and by
23 our board, you mean the ADM --

24 A. Yes.

25 Q. -- board of directors, or do you

1 mean the whole ADM Board, kind of, staff and
2 employees?

3 A. In this -- that case, it may have
4 been both, both the staff and the actual board
5 of directors, right.

6 Q. So when you say, "I recently told
7 our board," in this email you mean you told the
8 employees of the ADM Board for Summit County
9 and the board of directors for the ADM Board --

10 MS. KEARSE: Object to form.

11 Q. -- is that right?

12 A. That's correct. They asked -- they
13 asked the question. The board asked -- I gave
14 a presentation about the epidemic, and the
15 board asked, well, what would -- what is the
16 one way we could really resolve this, and I
17 gave them a lot of other answers, as I've given
18 today, but I did say if we could make -- change
19 all the laws, pressures and everything, and
20 roll back the clock to 1995 and treat pain the
21 way we did then, that would do it.

22 Q. Okay. You made a presentation to
23 the board of directors about the opioid
24 epidemic --

25 A. Yes.

1 Q. -- in 2016?

2 A. Yes.

3 Q. Was that at the board of directors'
4 request?

5 A. Yes.

6 Q. Did you prepare a slide deck, in
7 connection with that presentation?

8 A. I'm sure it's pretty much the same
9 one that I use, that you've got, my guess is,
10 20 copies of, but yes.

11 Q. I'm not sure we do have that. Is
12 that something that would have been in your --

13 A. Yes.

14 Q. -- in your documents?

15 A. It's part of everything that was
16 given, sure.

17 Q. Okay. Do you recall when you made
18 that presentation to the board of directors?

19 A. Well, since I said recently, that
20 probably means it was in late September of 16,
21 would have been probably two weeks -- a week or
22 two before this.

23 Q. And you said the board of directors
24 asked you a question, right?

25 A. Well, in advance, we determine what

1 topics. So most every board meeting, somebody,
2 many times it's other agencies that we contract
3 with, comes and gives a presentation to educate
4 our board, so they understand what's going on
5 in the system, and in this case they asked
6 about the opioid epidemic, because in July of
7 16, unfortunately, we were hit with synthetic
8 carfentanil, which was killing people at a very
9 high clip, and so they really wanted to have a
10 presentation about, all right, we knew it was
11 bad, now what's going on, basically.

12 Q. And they asked you a question, as I
13 understand it, "What is the thing that would
14 have or could -- would have stopped or could
15 stop the opioid epidemic?"; is that fair?

16 MR. KEARSE: Object to form.

17 A. The question was what -- what needs
18 to be done or could be done to stop this.

19 I think one of the -- in my mind's
20 eye, I'm remembering a person saying, "Stop
21 this madness."

22 Q. Another way of framing that
23 question might be, "What is the thing that has
24 caused that epidemic to have taken place"; is
25 that fair?

1 MR. KEARSE: Object to form.

2 A. It was sort of the corollary, flip
3 of the question, sure.

4 Q. And your answer was, "The best way
5 to prevent furthering this epidemic is to
6 return to the way we treated pain in about
7 1995," right?

8 A. That's correct.

9 Q. Is that what you told the board of
10 directors?

11 A. Yes, it is.

12 Q. And that's what you said in
13 response to Ms. Skoda's email, right?

14 A. Yes.

15 Q. What do you -- what did you mean by
16 that?

17 A. So again, I gave a bigger
18 presentation, but what I mean by that, and I
19 still believe it, is if we went back to only
20 using, whether it's Percocet, Vicodin,
21 prescription fentanyl, whatever, only for real
22 significant pain, extreme pain, cancer pain,
23 kidney stone pain, childbirth and the like,
24 that we would not -- that would be one way to
25 stop continuing furthering this epidemic,

1 because the epidemic, even if today we thought
2 we had stopped all those pills, addiction is a
3 chronic illness, so we are going to have years
4 of dealing with these people.

5 We have babies born addicted to
6 opiates, and they got a whole life,
7 potentially, to deal with. We still don't know
8 how that affects their brain.

9 So we got -- this is a long-term
10 process. It's not a, oh, it's a onetime event,
11 I'm addicted, I'm detoxed, I'm cured. This is
12 probably, because the disease of addiction, an
13 ongoing problem.

14 So this would be one way to stop
15 the furthering of the epidemic, and then we
16 would still have to deal with all the
17 aftereffects that will go on for many, many
18 years.

19 Q. And when you talk about the changes
20 between 1995 and, let's say, 2016, in terms of
21 the way pain was treated, are you talking about
22 the Joint Commission and the pain as the fifth
23 vital sign and those things that we have been
24 discussing today, or did you have something
25 else in mind?

1 A. Yeah. All of the above. OxyContin
2 being promoted as though it was not addictive,
3 pain as a fifth vital sign, patient
4 satisfaction, all the things that changed from
5 the time I was trained, be very careful about
6 potential causes of addiction, to don't worry
7 about it, we can just start handing out opiates
8 for all kind of pain. That was a huge -- many
9 factors, but that was a huge switch.

10 Q. Are you aware of any actual
11 instance or statement from the manufacturer of
12 OxyContin or the manufacturer of any opioid
13 medication that their opioid does not, in fact,
14 have addictive properties?

15 A. And they don't -- I don't prescribe
16 opiates, so I wasn't having pharmaceutical reps
17 come to me personally.

18 So my knowledge comes from reading,
19 you know, the various sources, talking to
20 doctors, the, sort of, big exposé, the book
21 Dreamland, from Sam Quinones, you know, that
22 describes how these articles, the Dr. Jick
23 article and so forth, were used to educate but,
24 in effect, convince physicians that, at least,
25 OxyContin was not addictive, and that that was

1 part of the upsurge of the use of these
2 medications for things that didn't and don't
3 need that kind of treatment.

4 Q. Understood. My question is
5 slightly different than that and more specific.

6 My question to you is whether or
7 not you are aware of any particular statements,
8 actual statements made by a pharmaceutical
9 manufacturer of an FDA-approved prescription
10 medicine, opioid medicine, that their product
11 does not have addictive properties?

12 A. I have not seen it, like, in the
13 FDA-approved handouts. I believe there were
14 some quotes in the Dreamland book.

15 Q. Okay. So you believe there is
16 something in Dreamland about that, but I'm
17 asking you whether or not, you, Dr. Smith, are
18 aware of any specific instances where the maker
19 of an FDA-approved opioid medication stated to
20 a physician that their product does not have
21 addictive properties?

22 MR. KEARSE: Object to the form.

23 A. Not directly, no.

24 Q. What about indirectly?

25 A. Again, I think I have read things

1 in articles and Dreamland and other places that
2 do indicate that that was being said by --
3 maybe not in writing, but said by reps,
4 pharmaceutical reps to physicians. I didn't
5 personally experience that.

6 Q. Okay. You're not aware -- you're
7 not personally aware of any such instances?

8 MS. KEARSE: Object to form.

9 A. I am not.

10 Q. Okay. As we mentioned, this
11 particular email exchange with Ms. Skoda
12 started with a forward of the DAE press
13 release. So let's look at that press release,
14 if we can, and I'll mark that separately as
15 Exhibit 12.

16 - - - - -

17 (Thereupon, Deposition Exhibit 12,
18 October 4, 2016 DEA Press Release,
19 was marked for purposes of
20 identification.)

21 - - - - -

22 Q. Dr. Smith, I have given you the
23 document marked as Exhibit 12.

24 MR. BOEHM: I'm sorry.

25 MR. KEARSE: I was going to say.

1 I'm not asleep.

2 MR. BOEHM: You are not, but I'm
3 getting there.

4 Q. I've marked as Exhibit 12 to your
5 deposition the DEA press release that was
6 referred to and forwarded to you by Ms. Skoda;
7 do you see that?

8 A. Yes.

9 Q. And the title is DEA Reduces Amount
10 of Opioid Controlled Substances to be
11 Manufactured in 2017; do you see that?

12 A. I see that.

13 Q. And the last line of your email in
14 what has been marked as Exhibit 11, states
15 that, "Maybe the DEA will help with that," and
16 I think "with that," you mean returning to
17 1995; is that right?

18 A. Yes.

19 Q. The DEA press release refers to the
20 DEA deciding to lower the aggregate production
21 quota, the APQ, for that year, correct?

22 A. Yes.

23 Q. Do you know what the APQ is?

24 A. I've never heard of it until this
25 document, no.

1 Q. Do you remember receiving this?

2 A. I do.

3 Q. Do you know what it is, as you sit
4 here today, what the APQ is?

5 A. I think the language speaks for
6 itself. It is the total number of controlled
7 substances that somebody has decided would be
8 enough to do drug treatments but not
9 overtreatment.

10 Q. And who is it that makes that
11 decision about the appropriate amount of
12 controlled substances to be manufactured?

13 A. That I do not know.

14 Q. You are not sure who does that?

15 A. No. I'll answer this. This may
16 tell us.

17 Q. I'll direct your attention to the
18 last paragraph.

19 MR. KEARSE: Allow the witness to
20 take the time --

21 Q. Of course. You can look at
22 whatever you want to answer any question, but I
23 think you may find, in particular, looking at
24 the last paragraph of the document, helpful in
25 that regard.

1 A. So it appears it is the DEA
2 themselves.

3 Q. It says in the final paragraph, "In
4 setting the APQ, DEA considers data from many
5 sources"; do you see that?

6 A. I see that.

7 Q. And then in your email again, you,
8 of course, also reference that maybe the DEA is
9 going to help, right?

10 A. Right.

11 Q. So you understood, when you wrote
12 this email, that it was the DEA who was setting
13 the AQP, this quota for the year, right?

14 MS. KEARSE: Object to form.

15 A. Well, I understood that they were
16 reducing, based on the title alone even, the
17 amount of opioid-controlled substances being
18 manufactured, which would decrease the
19 oversupply of pills.

20 Q. And you say -- well, backing up a
21 little bit, this paragraph goes on to identify
22 the factors that the DEA takes into account in
23 establishing the APQ each year; do you see
24 that?

25 A. I see that.

1 Q. It estimates the legitimate medical
2 need, right?

3 A. I see that.

4 Q. The amount of consumption, based on
5 dispensed prescriptions?

6 A. Right.

7 Q. Manufacturers' data, based on
8 actual production, sales, inventory, exports,
9 product development needs and manufacturing
10 losses?

11 A. Yes.

12 Q. And then, of course, DEA's own
13 internal system for tracking controlled
14 substances and transactions, right?

15 A. Yes.

16 Q. And DEA took all those factors into
17 account and exercised its regulatory authority
18 to establish what it views as the appropriate
19 amount of prescription opioids to ensure
20 adequate supply for legitimate medical needs,
21 while limiting it to prevent diversion, right?

22 MR. KEARSE: Object to form.

23 A. Yeah. That's what it says they are
24 doing, yes.

25 Q. Is that your understanding of what

1 the DEA does?

2 A. Again, this was the only time I
3 have ever seen it referenced, but, yes, when I
4 read this, that was what my understanding.

5 Q. Okay. Are you critical of the DEA,
6 in terms of opioid abuse, opioid epidemic, in
7 particular as it has impacted Summit County?

8 MS. KEARSE: Object to form.

9 A. No. I've never sat around and
10 thought that, no.

11 Q. You mentioned this book Dreamland?

12 A. Yes.

13 Q. Do you remember that?

14 A. Huh-uh.

15 Q. How much of your understanding
16 about the causes of the opioid epidemic comes
17 from you having read that book?

18 MR. KEARSE: Object to form.

19 A. I mean, I read the book after I had
20 what is on the slide set already as an
21 understanding. I do think the book supported a
22 lot of what Summit County together pulled and
23 felt were the causes.

24 Q. The author of that book, is he a
25 medical doctor?

1 A. No. An LA Times reporter, I
2 believe.

3 Q. LA Times reporter. Not an
4 epidemiologist?

5 A. No.

6 Q. Not a public health specialist?

7 A. No.

8 Q. Are you familiar with any specific
9 exposé-style reporting on the opioid epidemic,
10 insofar as it concerns Summit County?

11 MR. KEARSE: Object to form.

12 A. Exposé, meaning like a book?

13 Q. Yeah. The same style of reporting
14 that we get from the LA Times reporter in
15 Dreamland, but just particular to Summit
16 County?

17 A. No, not that I recall.

18 Q. Okay.

19 - - - - -

20 (Thereupon, Deposition Exhibit 13,
21 Report of the Ohio Compassionate
22 Care Task Force, was marked for
23 purposes of identification.)

24 - - - - -

25 MS. KEARSE: Once you get it on,

1 you can't take it off.

2 MR. BOEHM: You are making me
3 laugh, pointing out my mental health issues,
4 right here in front of the psychiatrist.

5 THE WITNESS: I was going to send
6 him my bill later.

7 Q. Okay. I think we are at Exhibit
8 13, and I've marked that document for you,
9 which is in front of you now. It's a document
10 entitled Report of the Ohio Compassionate Care
11 Task Force. Have you seen that document
12 before?

13 A. I don't recall seeing it, but that
14 doesn't mean I didn't.

15 Q. Did you know that the Ohio General
16 Assembly commissioned a task force to look into
17 compassionate care for the State of Ohio?

18 A. I don't believe I did until now,
19 actually, no.

20 MR. KEARSE: Is there a date on
21 this document?

22 MR. BOEHM: Yeah. I can show it to
23 you. 2004.

24 Q. And if you want to, kind of, skip
25 head to page 5, you can see there is a

1 reference to the legislative authority,
2 specifically that the Ohio General Assembly
3 enacted House Bill 474 December 2002, creating
4 the Compassionate Care Task Force; do you see
5 that?

6 A. Yes.

7 Q. And then if you flip back to the
8 background page, there is an explanation of,
9 kind of, what the task force was trying to do;
10 do you see that?

11 A. Yes.

12 Q. And there is a reference right at
13 the top to chronic pain?

14 A. Yes.

15 Q. It says, "Chronic pain is among the
16 most disabling and costly afflictions in North
17 America."

18 MR. KEARSE: I'm going to object to
19 form. The doctor said he hasn't seen this
20 document before. The document speaks for
21 itself.

22 MR. BOEHM: Well, right now I'm
23 just asking him is that what it says here.

24 Q. Do you see that it says that?

25 A. I see it.

1 Q. Again, this is, you know, in the
2 2003, 2004 time range. Do you agree or
3 disagree with the statement here by the Ohio
4 Compassionate Care Task Force that chronic pain
5 is among the most disabling and costly
6 afflictions in North America?

7 A. I'm thinking about all the top
8 causes I've seen listed. It's -- I doubt it's
9 in the top ten, but I won't disagree. It's an
10 issue.

11 Q. If you turn to page 6, you will see
12 that there is a list -- actually, it starts on
13 page 5 and carries over to page 6.

14 There is a list provided of the
15 individuals who participated on this task
16 force.

17 A. Uh-huh.

18 Q. Do you see that?

19 A. Yes.

20 Q. And you can see that it's primarily
21 experts in the medical profession, right?

22 A. Yes.

23 Q. And just to point to a few names in
24 particular, do you see the name Ted Parren?

25 A. I spotted it before you mentioned

1 it, yes.

2 Q. Do you know Dr. Parren?

3 A. Sure. He's a well-respected
4 addiction specialist in the Northeast Ohio
5 area, more in the Cleveland than Akron, and
6 actually gave one of our talks at that May 31,
7 conference, 2014, that you've already
8 referenced.

9 Q. And he participated in the creation
10 of the recommendations that are encompassed in
11 this document, this report of the Ohio
12 Compassionate Care Task Force, right?

13 A. Yes.

14 Q. And then in the second column on
15 page 6, there is another name, Sarah Frieibert
16 or Frieibert?

17 A. Frieibert.

18 Q. Do you know Dr. Frieibert?

19 A. Yes. She is part of our healthcare
20 subcommittee for our opiate task force.

21 Q. She works in Akron?

22 A. Yes, she does.

23 Q. She works at the Akron Children's
24 Hospital?

25 A. Yes. She is their director of

1 palliative care.

2 Q. What is palliative care?

3 A. Basically, people who are dying or
4 likely to die, chronic pain, she is an
5 oncologist, so cancer, in this case with kids,
6 and so she treats their pain, as the report
7 says, compassionately.

8 Q. Would you say that she's an expert
9 in the treatment of pain?

10 A. For that type of pain, yes.

11 Q. And it appears that she was
12 appointed to serve on this task force and
13 participated in the creation of this document,
14 correct?

15 A. Yes.

16 Q. I want to direct your attention to
17 page 11, where there is a discussion about
18 standards for palliative care or pain
19 management programs.

20 In particular, I'm going to ask you
21 about number 2 here, where it says,
22 "Patient-driven, outcome-based guidelines
23 should be used in providing pain management and
24 palliative care, such as, but not limited to";
25 have I read it correctly so far?

1 A. Yes.

2 Q. And the first thing it says is
3 chronic pain?

4 A. Yes.

5 Q. Do you have a view, one way or
6 another, as to whether or not it is
7 appropriate, or may be appropriate, depending
8 on the discretion of an individual healthcare
9 provider treating an individual patient, to
10 prescribe a prescription opioid medication to a
11 patient for chronic pain?

12 MR. KEARSE: Object to the form.

13 A. Well, my opinion is it depends on
14 which chronic pain. So, sure, if somebody has
15 a chronic pain due to some pervasive illness in
16 their body, and other medications haven't
17 worked, then there would be logic for that.

18 It wouldn't be logical to give --
19 to call an ankle sprain or tennis elbow chronic
20 pain and then treat that. So I think in this
21 case, chronic pain has got to be pretty serious
22 chronic pain. It is actually disabling, and
23 not just bothersome.

24 Q. And here it says, "Chronic pain,"
25 and then it says, "The VA/DoD Clinical Practice

1 Guidelines for the management of opioid therapy
2 for chronic pain," with a reference to the
3 Department of Veteran Affairs, 2003?

4 A. Yes.

5 Q. Do you know what practice
6 guidelines are being referred to there?

7 A. I'm not familiar with them. I
8 would imagine that veterans come back with
9 serious wounds from battle, and some of them
10 end up with chronic pain and they are helping
11 their prescribers treat that.

12 Q. And the use of FDA-approved
13 prescription opioid medicines may be
14 appropriate to prescribe to a patient in that
15 situation, fair?

16 A. Yes.

17 Q. We are going to set that one aside
18 for just a minute.

19 - - - - -

20 (Thereupon, Deposition Exhibit 14, A
21 Slide Deck Entitled Facing the
22 Opiate Epidemic: How We Got Here and
23 What we Need to do Next, Beginning
24 with Bates Label SUMMIT 822287, was
25 marked for purposes of

1 identification.)

2 - - - - -

3 Q. Dr. Smith, I have put in front of
4 you a document that I have marked as Exhibit
5 14. It is a slide deck from Dr. Christina
6 Delos Reyes from the May 31, 2014
7 opioid-related conference that you organized,
8 right?

9 A. Correct.

10 Q. And it looks like, from the title
11 of her slide deck, she wants to talk about
12 identifying causes of the increasing opioid
13 abuse. She asks, "How we got here," right?

14 MR. KEARSE: Objection to form.

15 Q. Do you agree with that
16 characterization?

17 A. Yeah, that's her title.

18 Q. Yeah. And one of the things she is
19 trying to do is identify the causes of
20 increasing levels of opioid abuse, right?

21 A. Well, the opioid epidemic, yes.

22 Q. The opioid epidemic.

23 Now, her slide deck is not numbered
24 on its own, but, of course, we have these Bates
25 numbers in the bottom right-hand corner, and

1 I'm going to ask you to turn in particular to
2 the slide that's on the page with the number
3 that ends 2321. So I think it is about halfway
4 in.

5 The top of the side, it says,
6 Contributing Factors; do you see that?

7 A. Yes.

8 Q. And it references these changes in
9 clinical pain management in the late 1990s that
10 you have been talking about, right?

11 A. Yes.

12 Q. And that you have identified as the
13 driver of the opioid epidemic itself, right?

14 MR. KEARSE: Object to form.

15 A. One of the contributors, yes.

16 Q. This slide references a 1998 policy
17 document from the Federation of State Medical
18 Boards of the United States; do you see that?

19 A. I see that.

20 Q. And there is a reference to, "Model
21 guidelines for the use of controlled substances
22 for the treatment of pain," right?

23 A. Yes.

24 Q. Do you know what that is?

25 A. I probably only heard about it from

1 Dr. Delos Reyes. So no, again, psychiatrists
2 don't tend to treat pain, so that would not
3 have been something that would have been part
4 of my education.

5 Q. Do you know what these model
6 guidelines from the Federation of State Medical
7 Boards of the United States said, with respect
8 to the use of controlled substances to treat
9 pain?

10 A. I do not.

11 Q. In the middle of the page, it says,
12 "Pain relief laws being pushed down to states
13 to address liability concerns among
14 prescribers"; do you see that?

15 A. Yes.

16 Q. Do you know what is being referred
17 to here?

18 A. I do not.

19 Q. There a reference to Ohio Revised
20 Code 4731.21, Drug Treatment of Intractable
21 Pain; do you see that?

22 A. I do.

23 Q. Do you know what that law is?

24 A. It appears to speak for itself.
25 This is the kind of pain I'm talking about. It

1 looks like they wanted to put something in the
2 law about treating intractable pain, and I
3 suspect it's a law that helps keep physicians
4 who need -- who spend their time trying to help
5 such people in such pain be protected from
6 scrutiny, because the DEA or others would look
7 and go, "My, God, you're giving out way too
8 many pain meds." So this is probably to allow
9 them, under very refined circumstances, to
10 treat it.

11 Q. Okay. So in 1997, the DEA might
12 have said to certain doctors, "Hey, you're
13 prescribing too many opioid medications," and
14 this law would have been designed to provide
15 relief to those physicians, so that they could
16 exercise their independent medical judgment --

17 MR. KEARSE: Object to form.

18 Q. -- to prescribe or not prescribe,
19 as appropriate; is that your understanding?

20 A. Well, for very specific types of
21 terrible chronic pain, right.

22 Q. Have you read this, this Ohio
23 Revised Code 4731.21 legislation?

24 A. I don't recall reading it, no.

25 Q. Do you know why it was included on

1 Dr. Delos Reyes' slide deck?

2 A. Yeah. Dr. Delos Reyes, as an
3 addiction specialist, she does, in her small
4 private practice, treat people that basically
5 nobody else will treat, that is people who have
6 an addiction to opiates, but also have true
7 pain and needs care, and so she tries to
8 balance these things.

9 Even pain specialists won't treat
10 them, and other people won't treat them, so
11 she -- so I suspect that she would be the
12 one -- in fact, the only one I know in all of
13 Northeast Ohio would treat such individuals.

14 Q. Would she sometimes treat those
15 individuals by prescribing FDA-approved
16 prescription opioid medicines, even if there
17 were addiction issues?

18 A. I'm assuming, yes, but I don't
19 know. I don't know her practice.

20 Q. You getting buried by paper?

21 A. I think we're good. Although this
22 sticker is a little crooked.

23 Q. Oh, no. We have to start over.
24 Let's start from the top. Now you, as a
25 medical doctor, should not be preying on my --

1 A. Humor is a good thing, so...

2 - - - - -

3 (Thereupon, Deposition Exhibit 15,
4 2010 Final Report From an Ohio
5 Prescription Drug Abuse Task Force,
6 was marked for purposes of
7 identification.)

8 - - - - -

9 Q. How did I do on that one? Does it
10 look okay?

11 A. It looks pretty good, actually.

12 Q. The sticker that we have been
13 referring to marks this particular document as
14 Exhibit 15, for purposes of your deposition.

15 Exhibit 15 is a 2010 final report
16 from an Ohio Prescription Drug Abuse Task
17 Force, right?

18 A. Yes.

19 Q. Have you read this report before?

20 A. I believe Dr. Thrasher actually
21 gave it to me at one point to look at. I don't
22 know that I have read it cover to cover, but I
23 have certainly looked at it.

24 Q. You said that when you came to the
25 ADM Board in 2012, you hadn't really focused on

1 opioids and opioid-addiction-related issues,
2 but when you came to the board, you wanted to
3 do everything you could to try and understand
4 that issue, right?

5 MR. KEARSE: Object to form.

6 A. Certainly. Anything that would
7 help us understand how ADM and then the Opiate
8 Task Force could help.

9 Q. Is this report the kind of thing
10 that you would have wanted to look at to make
11 sure that you understood the contours of the
12 opioid epidemic, when you came to the ADM
13 Board?

14 MS. KEARSE: Object to form.

15 A. Yes. That's why Dr. Thrasher gave
16 it to me, although I don't think I saw it until
17 2014 or something, but, yes.

18 Q. If you turn to the third page of
19 the document, you can see a letter that's being
20 written to Governor Strickland. He was the
21 governor of Ohio at that time, right?

22 A. Yes.

23 Q. Governor Strickland, in 2010,
24 established a task force to address the opioid
25 epidemic in Ohio, right?

1 MR. KEARSE: Object to form.

2 A. Yeah. That's the title of the
3 document, so...

4 Q. Did you know that before today?

5 A. I think I knew it like in 2014. He
6 was a psychologist, the governor.

7 Q. But sitting here today, you now
8 know that in 2010, Ohio had already identified
9 opioid-related issues as an epidemic?

10 MS. KEARSE: I want to object to
11 the form. It mischaracterizes his testimony.
12 He just testified in 2014 he saw this document.

13 MR. BOEHM: That doesn't in any way
14 mischaracterize --

15 MR. KEARSE: You just suggested
16 it --

17 MR. BOEHM: Don't coach the
18 witness. You can object to form. The question
19 stands.

20 MR. KEARSE: And
21 mischaracterization, I can highlight that as
22 well.

23 Q. Did you keep my question in mind,
24 or did that all fuzzy it up for you?

25 A. I would say please repeat it.

1 MR. BOEHM: Let's go back up, if
2 you don't mind.

3 THE NOTARY: Question: "But
4 sitting here today, you now know that in 2010,
5 Ohio had already identified opioid-related
6 issues as an epidemic?"

7 MR. KEARSE: Object to form.
8 Mischaracterizes his testimony.

9 Q. You can answer.

10 A. So, yes, I saw this probably in
11 2014, but was not aware of it when I was still
12 at the state hospital system in 2010.

13 Q. But my question is, sitting here
14 today, you now know that it had been identified
15 as an epidemic at the latest by 2010, right?

16 MR. KEARSE: Object to form.

17 A. Clearly, something about opiates,
18 they call it drug abuse, had been identified by
19 2010, yes.

20 Q. And it uses the term "epidemic"
21 right there in the first sentence, right? It
22 is the last word in the first sentence of the
23 document --

24 A. Yes.

25 Q. -- right?

1 So you agree, right --

2 A. Yes.

3 Q. -- with the way I have asked the
4 question?

5 MR. KEARSE: Object to form.

6 Q. Yes?

7 A. I agree that in 2010, they were
8 aware there was a problem and the governor
9 started to work on it.

10 Q. And, in fact, by October of 2010,
11 this task force had completed its work and
12 developed 20 policy recommendations to try to
13 curb Ohio's prescription drug abuse, and they
14 used the word "epidemic," right?

15 A. Yes.

16 MR. KEARSE: Object to form.

17 Q. As you sit here today, as the
18 medical director and chief clinical officer of
19 the Summit County opiate -- or I'm sorry -- of
20 the Summit County ADM Board, what is your
21 understanding as to when public officials in
22 Ohio first recognized the issues related to
23 opioid abuse that are now the subject of the
24 lawsuit that Summit County has filed?

25 MR. KEARSE: Object to form.

1 A. So Ohio, as a state, I don't know.
2 Summit County I can talk about, and I know that
3 the original discovery, I think, of the
4 epidemic really focused on Southern Ohio, in
5 Scioto County, this may very well reflect that,
6 that Summit County, again, was not something
7 that was being discussed until -- really until
8 2013.

9 Q. Well, we have already seen that
10 that's not true, haven't we today, by looking
11 at some of the documents in the stack?

12 MR. KEARSE: Object to form.

13 A. No. That was a conference in 2012
14 that was in Columbus. That was a state thing,
15 not a Summit County conference.

16 Q. Do you know when Cuyahoga County
17 set up its Opiate Task Force?

18 A. About a year or two before Summit
19 County, but again, my focus has been Summit
20 County, so...

21 Q. As part of your responsibilities
22 for trying to understand drug addiction in
23 Summit County, did you ever communicate with
24 public health officials and corresponding ADM
25 Board members in the neighboring county of

1 Cuyahoga?

2 MR. KEARSE: Object to form and to
3 tone.

4 A. So once -- I've said that already.
5 Once we realized there was an issue, yes, I
6 went to their task force, which was already set
7 up, to gain as much knowledge as possible, but
8 I didn't attempt to gain knowledge until I knew
9 there was a reason to obtain it.

10 Q. And unfortunately, you, in your
11 search and efforts to try to understand opioid
12 abuse in 2012, just didn't come across this
13 report from the Opiate Task Force that Governor
14 Strickland had set up in 2012?

15 MR. KEARSE: Object to form.
16 Argumentative.

17 A. No, that's correct. New governor,
18 I guess they didn't share it.

19 Q. "They didn't share it," what do you
20 mean, "They didn't share it"?

21 A. Meaning, when I was talking to the
22 people at ODMH and then it became ODMHAS, this
23 is not one of the things that they shared.

24 Q. You know that this is publicly
25 available, right? You can see that on the --

1 A. True, true.

2 Q. -- first page of the document?

3 A. It's government, true.

4 Q. Publically --

5 A. It doesn't mean you can magically
6 know it exists.

7 Q. Well, you don't have to use magic,
8 right? There is an actual specific reference.
9 I don't need to have gone to Hogwarts to find
10 this document, do I?

11 MR. KEARSE: Object to form.
12 Condescending.

13 A. But when you are searching for
14 documents, that doesn't mean they all magically
15 show up. So if I didn't run across it, I
16 didn't run across it.

17 Q. What kind of searches did you
18 undertake?

19 A. Mostly through the addiction
20 specialists at the hospitals. So Dr. Thrasher,
21 Dr. Shane, Dr. Labor, they were the ones who I
22 relied on as my experts, to provide me the
23 information I needed. This was not -- not
24 until 2014, when Dr. Thrasher gave it to me.

25 Q. Have you read it ever; have you

1 ever read this document?

2 A. I'm sure I did back in 2014.

3 Q. If you turn to, let's say it is
4 page 21. Do you see that it says on this page,
5 "How did this become an epidemic"; do you see
6 that?

7 A. Yes.

8 Q. So the task force that was
9 assembled by Governor Strickland in 2010
10 reaches conclusions about the causes of what
11 they are calling an opioid epidemic in the
12 State of Ohio, right?

13 A. Yes.

14 Q. And there is this graph on the
15 bottom of the page. I don't know if graph is
16 the right word, some depiction of those causes,
17 right?

18 A. Yes.

19 Q. One is aggressive marketing of
20 opioids. You have already talked about that,
21 right?

22 A. Yes.

23 Q. Two is changes in clinical pain
24 management?

25 A. Yes.

1 Q. You have already talked about that.

2 Three is growing use of
3 prescription opioids; do you see that?

4 A. Yes.

5 Q. I'm not going in any particular
6 order, but four is direct-to-consumer
7 marketing. You already talked about that?

8 A. Yes.

9 Q. Five says self-medicating habits of
10 baby boomers. I think you at least referenced
11 that earlier today, right?

12 A. Yes.

13 Q. And then six, you mentioned
14 diversion, specifically internet, pill mills,
15 deception/scams, theft, friends and family?

16 A. Yes.

17 Q. And we already talked about that as
18 well, right?

19 A. Yes.

20 Q. Is it fair to say that, based on
21 this document from October 2010, the task force
22 was reaching conclusions about what caused the
23 epidemic related to opioids that are the same
24 conclusions that the Summit County ADM Board
25 reached in whatever subsequent years, when you

1 all started looking at the problem; is that
2 fair?

3 A. Yes. In fact, we use a similar
4 graphic in our speakers bureau for the Opiate
5 Task Force about the causes.

6 Q. In spite of the complexity of the
7 issues that we have been talking about today,
8 do you agree that opioid medications have
9 legitimate medical purposes?

10 A. Yes.

11 Q. Do you agree that doctors need to
12 be afforded some discretion in exercising their
13 individual medical judgment about whether a
14 particular patient has a legitimate medical
15 need for a prescription opioid?

16 A. Yes. As I have said, I think that
17 needs to be unfettered by outside forces,
18 though, that are either encouraging them to use
19 or not use something, when it is not really a
20 clinical decision at that point.

21 Q. Okay. In other words, a
22 prescribing physician is the person who
23 interacts directly with the patient, right?

24 MS. KEARSE: Object to the form.

25 A. Yes.

1 Q. As a medical doctor, why is that
2 important? Why is it important; why does it
3 matter, in terms of making prescribing
4 decisions, that the medical doctor, the person
5 who is there with the patient, has the
6 discretion to exercise their professional
7 medical judgment?

8 MR. KEARSE: Object to form.

9 A. Well, at that point in time, that's
10 the only person who's got the education and
11 experience, and then the data, by talking to
12 the person, as well as hopefully getting other
13 records and so forth, to make a mutual decision
14 with the patient about what is in his or her
15 best interest.

16 Q. They could take a medical history
17 of that person, right?

18 A. Certainly.

19 Q. They can perform an examination?

20 A. Yes.

21 Q. They can look the patient in the
22 eye, right?

23 A. Correct.

24 Q. Does that matter, in making medical
25 decisions, to be able to be right there with

1 the person?

2 A. Yeah. In fact, we are not really
3 able to make a diagnosis of somebody we haven't
4 seen. So that's kind of a requirement.

5 Q. And then taking all that
6 information into account, that particular
7 healthcare provider can apply medical judgment,
8 right?

9 A. Correct.

10 Q. And your view is that medical
11 judgement should not be fettered, one way or
12 another, either in terms of false inflating
13 their likelihood of prescribing an opioid or
14 discouraging the prescription of an opioid,
15 when it might be in that patient's best
16 interest, right?

17 A. Yeah. As long as it's, you know, I
18 guess, completely unfettered, but the truth is
19 medical science changes. So if there is new
20 science that says something is the right
21 treatment, and there is evidence based to it,
22 then obviously, hopefully, the physician will
23 have that at his or her disposal to take into
24 account.

25 Q. Okay. Now just to back up for a

1 moment, we have been talking about opioids, but
2 to be clear, there is an important distinction
3 to be made between prescription opioid medications
4 and opiates that are illegal, not approved by
5 the FDA, and not appropriate for any legitimate
6 medical need; is that right?

7 MR. KEARSE: Object to form.

8 A. Yes. So there are medications
9 approved, tested, manufactured to certain
10 specifications, and they definitely differ from
11 what you might buy on the street, not knowing
12 what you are getting.

13 Q. Sometimes those are all referred to
14 as opiates, but there is a difference between
15 FDA-approved prescription opioid medicines and
16 street drugs that also sometimes get referred
17 to as opiates, right?

18 A. There may be, yes.

19 Q. Well, what do you mean when you
20 say, "There may be"?

21 A. Pills get diverted, so you might be
22 selling me OxyContin that you didn't take or
23 you got from your neighbor's medicine cabinet.
24 So that would be a real medication, but
25 diverted to the street.

1 Q. Understood. But I'm talking about
2 the actual substances. There is a difference
3 between an FDA-approved prescription opioid
4 medicine and heroin, for example, right?

5 A. Yes.

6 Q. What does it mean that a medicine
7 has been approved as safe and effective for its
8 indicated uses by the Food and Drug
9 Administration?

10 A. Well, so medicines go through a
11 pretty -- I think in this country, the most
12 rigorous of any country process to make sure
13 they are first and foremost not toxic, and then
14 next they have to be proven to serve the
15 purpose for which they are meant.

16 So they have to cause the positive
17 effect, at least a certain percent of
18 individuals compared to placebo generally, and
19 then they get approved, and then they are
20 allowed to be -- physicians can then be
21 educated about them and then prescribe them.

22 Q. Does the FDA employ subject matter
23 experts, as part of that testing, review and
24 approval process?

25 MR. KEARSE: Object to form.

1 A. Subject experts on what?

2 Q. Well, for example, drug safety,
3 epidemiology, toxicology, all the issues that
4 would go into an assessment of whether or not
5 something is safe and effective for its
6 indicated uses.

7 MR. KEARSE: Object to form.

8 A. So, yes, they have people that are
9 part of that pipeline, to make sure the
10 research is being done appropriately and
11 outcomes are what they appear to be.

12 Q. And you said that the United States
13 has the most rigorous drug-testing system in
14 the world, right?

15 A. That's my understanding, yes.

16 Q. And what does that mean; what do
17 you mean by that?

18 A. Other countries may release
19 medications with less rigorous research studies
20 than the U.S., and the big example of that was
21 thalidomide, quite a long time ago.

22 It was brought out as an antinausea
23 drug during pregnancy. FDA said, "No, not in
24 this country," and other -- in Europe there
25 were a lot of individuals born with missing

1 limbs and so forth. There were some born here.
2 That's because those individuals managed to get
3 thalidomide illegally from the other countries.

4 So that's an example of where the
5 FDA protected a lot of the U.S. citizens by not
6 being so -- not being so -- you know, not being
7 too streamlined, if you will, on the process of
8 approval.

9 Q. Do you know how long it typically
10 takes between the development of a compound and
11 it's approval as a medicine by the FDA?

12 MR. KEARSE: Object to form.

13 A. Years. I don't know how many
14 years. I think the total -- there is like a
15 17-year window from compound to end of patent,
16 but I don't know how many years, and that
17 probably varies by drugs, how many years.

18 Certainly there are some drugs that
19 have come out, HIV, cancer, things where the
20 trials are so compelling that they move even
21 faster, and they will get them on the market
22 quickly, because it will save lives, that's
23 certainly a good decision, and there are others
24 that it's not as clear, maybe this
25 antidepressant is new, let's see if it's better

1 than the other 15 we have. That probably goes
2 through the full process, before it comes out.

3 Q. When the FDA approves a medication
4 as safe and effective for specific uses, it
5 approves it for particular indications, right?

6 A. Correct. And that's based on what
7 the research was done for that indication.

8 Q. And for those who may not be
9 familiar with all the medical terminology, what
10 does it mean when we talk about approval of a
11 medication as safe and effective for the
12 approved indications?

13 A. Well, so if they studied a
14 particular opiate for use in a particular type
15 of pain, then it would get approved for that
16 particular type of pain, and similar to
17 antidepressants, there are some that have been
18 studied specifically, say, Paxil, for social
19 anxiety.

20 So Paxil comes out, and they have
21 done extra studies that say not only is it an
22 antidepressant, it's also for social anxiety.
23 That would be an evidenced-based indication
24 and, therefore, the FDA would approve it for
25 that indication.

1 Q. And this process that we have been
2 talking about was followed with respect to all
3 of the FDA-approved opioid medications that are
4 on the market in the United States today,
5 correct?

6 A. Yes.

7 Q. But when you talk about opiates, as
8 a member of the Summit County ADM Board, you
9 are also talking about substances that have
10 never been approved, have never been even
11 contemplated for use for legitimate medical
12 needs, right?

13 MR. KEARSE: Object to form.

14 Q. You are also talking about illicit
15 drugs?

16 A. Correct. We want to treat
17 addiction, no matter where the opiate came
18 from.

19 Q. And these illicit drugs, like
20 heroin, don't get prescribed by doctors, right?

21 A. No. They certainly shouldn't, no.

22 Q. They don't get dispensed by
23 pharmacies?

24 A. No.

25 Q. They are not FDA approved?

1 A. No.

2 Q. They are illegal street drugs,
3 right?

4 MS. KEARSE: Object to form.

5 A. Correct.

6 Q. You mentioned earlier today
7 something about carfentanil.

8 A. Yes.

9 Q. And there has been some reference,
10 I think, also to fentanyl, and you know what
11 those drugs are, right?

12 A. Yes.

13 Q. And those are -- to the extent
14 those are being abused in Summit County, those
15 are not, at least by and large, prescribed
16 fentanyl or carfentanil, right?

17 A. Yeah, correct. Carfentanil is an
18 elephant tranquilizer, only used for very large
19 animals, none of which are even in the Akron
20 zoo, for that matter, so it is not prescribed
21 here anywhere.

22 And fentanyl, there is a
23 prescription version of that, but what
24 generally is referred to as synthetic fentanyl
25 that is coming, apparently, from China, in the

1 U.S. Mail.

2 Q. And synthetic fentanyl that is
3 showing up in Summit County and other
4 communities, that's not something that is being
5 prescribed by a healthcare provider to
6 residents here in Summit County, right?

7 A. Right. No.

8 Q. I take it you have communicated
9 with law enforcement in various ways, insofar
10 as it concerns the opioid epidemic in Summit
11 County; is that true?

12 MR. KEARSE: Object to form.

13 A. Yeah. Our task force has over 400
14 members of all three branches of government,
15 police chiefs, et cetera.

16 Q. So based on your understanding from
17 your work on the Summit County ADM Board, and
18 specifically as its medical director, what is
19 your understanding about how addicts typically
20 obtain illicit street opiates, like heroin or
21 fentanyl or carfentanil?

22 A. So, you know, in fact, we have done
23 programs on this, but basically, as what we
24 have seen is the vast proportion of people who
25 end up with the disease of addiction, opiate

1 use disorder, started with pills, many times,
2 again, legitimately, coming from their
3 physicians, and then they, when they can't get
4 them anymore, or at least because, again, we
5 have shut down doctor shopping and we have shut
6 down pill mills and all these various
7 resources, we have got prescribers prescribing
8 more similarly to what they would have years
9 ago, before the epidemic.

10 They then seek out -- again, they
11 have an addicted brain, and that definition
12 again is that the person either is using,
13 thinking about using, or obtaining the drugs to
14 use by any means possible at that point, and so
15 they then go to the street, looking to find
16 somebody who will sell them heroin, but in
17 today's world, heroin may be tainted with
18 fentanyl or, sadly, with very deadly
19 carfentanil.

20 And so they seek out drug dealers,
21 because they, number one, they want to continue
22 that addiction, that's what their brain is
23 telling them, and number two, they don't want
24 to go in withdrawal. So they actually have two
25 motivators to maintain their addiction. If

1 they go into withdrawal, it affects nearly ever
2 system of their body, and it -- basically
3 people with addiction will tell you it feels
4 like a true case of influenza, not that they
5 have sniffles and a cough and they call it the
6 flu, but actual influenza, that is just
7 miserable.

8 So they really have two reasons at
9 that point, from an addicted brain point of
10 view, to seek out any version of opiate they
11 can get, which, sadly, means they end up taking
12 risks, to take things that they know their
13 neighbor just died from, but they think they
14 will be careful, because they are not really
15 thinking.

16 Q. You mentioned that -- I think
17 earlier you said that some addicts try to get
18 their hands on and abuse prescription opioid
19 medicines, correct?

20 MR. KEARSE: Object to form.
21 Mischaracterizes his testimony.

22 Q. Oh, well, if you disagree with
23 that, please do let us know.

24 MR. KEARSE: Well, I don't think
25 he's called them addicts. So I think you are

1 putting words in his mouth that he hasn't
2 actually stated. So mischaracterizes his
3 testimony.

4 MR. BOEHM: Would you just read
5 back my question, and see if it works between
6 me and the doctor.

7 THE NOTARY: Question: "You
8 mentioned that -- I think earlier you said that
9 some addicts try to get their hands on and
10 abuse prescription opioid medicines, correct?"

11 MR. KEARSE: Again, I object to the
12 form. Mischaracterizes his testimony.

13 A. Okay. So I think what I said was
14 people who have an addicted brain, they have
15 the disease of addiction, at that point they
16 were truly driven. It's not a thought process
17 at that point. They are really truly driven to
18 find opiates.

19 They no doubt first seek out the
20 pills, whether that is in your medicine cabinet
21 or the neighbor's medicine cabinet or
22 eventually the street, and when they can't find
23 them, they will go to the street looking for --

24 Q. I'm worried that the exchange
25 between the lawyers made you, kind of, lose

1 focus on the question.

2 My question, again, is I think -- I
3 thought you already said this. I was just
4 trying to confirm something I though I heard
5 you say, so tell me if I'm understanding for
6 sure.

7 MR. KEARSE: And he has answered
8 your question.

9 MR. BOEHM: I'm not talking right
10 now, Anne, I'm asking a question.

11 Q. Some people who are addicted to
12 opiates try to get their hands on and abuse
13 prescription opioid medications; did I
14 understand that correctly?

15 A. That is correct. People who are
16 addicted will try to find pills, yes.

17 Q. How does that most commonly happen?
18 As opposed to going out on the street and
19 buying heroin from a dealer, how do people who
20 are addicted to opiates get their hands on, for
21 purposes of abuse, prescription opioid
22 medicines that have been approved by the FDA
23 for legitimate medical needs?

24 MR. KEARSE: Object to form.

25 A. So prior to OARRS and similar

1 processes around the country, they would doctor
2 shop. So I would not know -- pretend I'm a
3 pain specialist. I wouldn't know that they
4 came in and told me they had pain today, and I
5 gave them Percocet, and then they went to
6 another doctor and got more and so on and so
7 forth.

8 So they would want -- number one,
9 they would doctor shop, trying to obtain these
10 pills. They would go to emergency departments,
11 often complaining of a toothache, which was
12 kind of genius, because doctors are not
13 dentists, and they will just say, "Oh, my gosh,
14 toothaches hurt, so I better give you some
15 opiates," and they would get opiates that way.
16 So initially they would try to get it that way.

17 When we shut that pathway down,
18 then they start looking in people's medicine
19 cabinets and, eventually, they may even go to
20 the street and ask if they can buy pills,
21 because they don't necessarily want to trust
22 heroin. So they will ask if they can buy
23 pills. Those are probably the main ways they
24 seek them out.

25 Q. When you talk about shutting down

1 doctor shopping, what do you mean by that?

2 A. So the OARRS report was designed,
3 in the beginning at least, the way it was
4 couched in 14 and then mandatory April 1 of 15,
5 was so that a patient couldn't get away with
6 that.

7 In other words, if they came in to
8 me to get a controlled substance, there is a
9 reason they are controlled, obviously, then I
10 can look it up and make sure they didn't just
11 get that same or a similar substance from
12 another physician or another prescriber.

13 So that would be OARRS preventing
14 doctor shopping. So that I use it, pharmacies,
15 by the way, are also required to use it, so
16 they also would be aware if you have got a
17 person who has gone down the path of addiction
18 and is trying to get more pills than would be
19 medically necessary.

20 Q. Okay. Other than that doctor
21 shopping, how do addicts, who are trying to get
22 their hands on prescription opioid medications
23 for abuse, how do they do that, other than the
24 things you have already mentioned, or did you
25 give me a comprehensive list?

1 MR. KEARSE: Object to form.

2 A. There is at least one other way I'm
3 aware of. They read the obituaries. They read
4 the obituary, and in the obituary, people will
5 put in, "My grandmother bravely fought off
6 cancer," just to, kind of, give some honor to
7 their loved one, and then in that same
8 obituary, it will tell the drug addict when no
9 one is home. "Oh, we'll all be at the funeral
10 home or the viewing," and they -- you have lost
11 your loved one, now they break into your home
12 or her home while you are at the funeral, and
13 they take all their pills, because they are
14 pretty sure there is probably a cache of pills,
15 and there probably was, in their medicine
16 cabinet.

17 So that would be another example.
18 They would be -- again, this part of the brain
19 is not completely gone, but it is being
20 deceived by the addicted part of their brain,
21 and so they are able to think things out, they
22 are able to plan, they are able to scheme, they
23 are able to start to sell things, their
24 parents' TV and whatever, to be able to
25 accomplish their goal, because it's a disease.

1 Q. So that would fit into the category
2 of, kind of, theft, right?

3 A. Yes.

4 MR. BOEHM: Would now about a good
5 time for a break? What do you all think? I
6 could use five minutes to walk around.

7 We will go off the record.

8 THE VIDEOGRAPHER: Off the record
9 at 3:16.

10 (Recess taken.)

11 THE VIDEOGRAPHER: We are back on
12 the record, 3:40.

13 Q. Okay. We are back from break, Dr.
14 Smith.

15 Before we broke, you were making
16 some references to something that you called
17 doctor shopping; do you remember that?

18 MR. KEARSE: Object to form.

19 A. Yeah. Addicted patients, shopping
20 for more than one doctor, yes.

21 Q. And as I understand it, when you
22 talk about doctor shopping, you are talking
23 about a situation where an addicted patient
24 goes from one doctor to the next doctor, maybe
25 multiple doctors, trying to get as many

1 prescriptions of opioids as that person can; is
2 that right?

3 A. Correct. Somebody with an
4 addicted -- the disease of addiction is driven
5 to obtain the medication.

6 Q. And that, in that situation, the
7 healthcare providers wouldn't know that that's
8 what that particular patient is doing; is that
9 right?

10 A. Not without some other way of
11 policing them, no. They come in, you want to
12 treat the person in front of you, you don't
13 know that they just got pills yesterday.

14 Q. And you're not blaming the doctor
15 in that situation, right?

16 MR. KEARSE: Object to form.

17 A. No. It's the disease of addiction
18 at that point that's at play.

19 Q. And the doctor is trying to address
20 what he or she perceives to be a legitimate
21 medical need, right, doesn't know that they are
22 the third or fourth doctor in the line for that
23 particular patient, right?

24 A. Correct.

25 Q. And for some time in Ohio, doctors

1 wouldn't have had the tools available for them
2 to reliably make a determination as to whether
3 or not that kind of doctor shopping was
4 happening, fair?

5 A. Correct.

6 Q. I think you said that OARRS didn't
7 become mandatory until 2016?

8 A. I believe, mandatory, I believe,
9 April 1 of 2015. And discussed maybe starting
10 in 14, as it was at our conference.

11 Q. Do you know why it wasn't until
12 April of 2015 that OARRS reporting became a
13 requirement in Ohio?

14 A. No. I don't know why that
15 particular date, as opposed to an earlier date.

16 Q. Did you or others for the Summit
17 County ADM Board ever advocate for an earlier
18 implementation of mandatory OARRS usage?

19 A. Again, we have an advocacy policy
20 subcommittee, and they very well may have done
21 that. I don't -- I don't know everything that
22 each of the six committees is doing, so I don't
23 know.

24 Q. Did the Summit County ADM Board
25 have a position, prior to April 2015, about

1 whether or not OARRS reporting should be
2 mandatory in Summit County and the State of
3 Ohio?

4 MR. KEARSE: Object to form.

5 A. I don't know that we had a
6 position. It's not really our role to take
7 positions on such things. So we never would
8 have had a formal position, even if we had that
9 belief.

10 Q. When you say, it is not your role,
11 the role of the Summit County ADM Board to take
12 positions on that sort of thing, tell me what
13 you mean by that?

14 A. I mean, we are not designed as an
15 advocacy group. We don't have a lobbyist, we
16 don't do any of that kind of work. The Opiate
17 Task Force, because it had the arm that brought
18 in some legislators and so forth, could
19 potentially have taken that role and run.

20 Q. Do you remember your email in
21 February 2014 announcing the May 2014
22 conference that you were organizing around
23 opiates?

24 A. Yes.

25 Q. And in your email, you said the way

1 to address this is, in part, through new
2 legislation; do you remember that?

3 A. Correct. Yes.

4 Q. So you, at least, had some views,
5 either in your official or unofficial capacity
6 as the medical director for Summit County's ADM
7 Board, about what type of legislation or public
8 policy process you should put in place to
9 address the opioid epidemic, right?

10 MR. KEARSE: Objection to form.

11 A. Sure. I mean, I think when you are
12 in the midst of a difficult actuation, you are
13 going to come up with a lot of views and
14 opinions about things that could be helpful.

15 Q. And that's really the nature of my
16 question, with respect to OARRS.

17 Was it your position, either
18 personally or in your official capacity as the
19 medical director for the Summit County ADM
20 Board, that the required use of OARRS ought to
21 have been put into effect prior to April 2015?

22 MR. KEARSE: Objection to the form.

23 A. I honestly doesn't know that I
24 thought about it from a mandatory point of
25 view. My role was to try to educate physicians

1 that it already existed and they, therefore,
2 could and should use it.

3 As far as making it a law, that's
4 not my -- I wouldn't have had an opinion about
5 law, at that point.

6 Q. Well, if only some doctors are
7 using it and others aren't using it, that takes
8 away the reliability of it; doesn't it?

9 A. I agree. Similarly, if -- because
10 pharmacies are also -- have to use it. If they
11 are not using it, same issue, right.

12 Q. And when you talk about doctor
13 shopping, that is illegal conduct, right? It
14 is against the law to engage in doctor
15 shopping?

16 A. It probably is. It's certainly
17 unethical. I don't know whether there is a law
18 against it or not, actually.

19 Q. Okay. And so is theft, right, if
20 somebody is stealing somebody else's
21 medication?

22 A. Yeah. That is certainly illegal.

23 Q. That's illegal. And so is sneaking
24 into your grandma's medicine cabinet and
25 stealing her medication for abuse, that's also

1 illegal, right?

2 MR. KEARSE: Object to form.

3 A. Yeah. You are not supposed to use
4 a prescription that's for somebody else, and
5 you use it, and you are not -- if I'm given a
6 prescription, I'm also not supposed to loan her
7 one --

8 Q. Right.

9 A. -- either. So either direction,
10 it's not proper.

11 Q. If I'm given a prescription for
12 this controlled substance, a prescription
13 opioid medication, it would be unlawful for me
14 to say, "Hey, you use it," or sell it to
15 somebody else, right?

16 A. Yes. Both would be illegal, and
17 worse would selling it, sure.

18 Q. And you talked about the means by
19 which patients addicted to opioids obtained
20 prescription opioids, not the street drugs, but
21 the prescription opioids; we talked about some
22 of the ways, right?

23 A. Yes.

24 Q. And I want to show you a document
25 from 2012 from the Ohio Department of Alcohol,

1 Drug Addiction Services that addresses that
2 issue.

3 - - - - -

4 (Thereupon, Deposition Exhibit 16, A
5 Document From 2012 from the Ohio
6 Department of Alcohol, Drug
7 Addiction Services, was marked for
8 purposes of identification.)

9 - - - - -

10 Q. I'm going to mark this document as
11 number 16. Do you see at the top it says
12 Ohio's Attack on the Opiate Addiction and
13 Overdose Epidemic; do you see that?

14 A. Yes.

15 Q. And this says SFY 2012 Annual
16 Report?

17 A. Yes, state fiscal year. Yes.

18 Q. So this is about the year 2012,
19 right?

20 A. It is about 2012, but it would have
21 come out in July of 13 or later, because the
22 state fiscal year would be July 1 of 12, right.

23 Q. It is addressing data from 2012?

24 A. Yeah.

25 Q. And if you turn to the back page,

1 you can see some graphics.

2 MR. KEARSE: I would just ask,
3 counsel, does this -- does this have a date?

4 MR. BOEHM: It says SFY 2012.

5 MR. KEARSE: Okay.

6 MR. BOEHM: So that's why I was
7 asking about that.

8 Q. So if you turn to the back page of
9 the document, you can see some graphics about
10 opiate abuse in Ohio; do you see that?

11 A. Yes.

12 Q. And several of these are
13 interesting, but the one I want to direct you
14 to has -- has to do with the subject we were
15 talking about before the break, How
16 Prescription Opiates Are Obtained For Abuse,
17 and do you see that, that's one of the graphics
18 here, about a third of the way down the page,
19 on the right side?

20 A. Yes.

21 Q. And it breaks out the different
22 means by which opiate addicts were obtaining
23 prescription opiates for the year 2012 into
24 different percentage categories, right?

25 A. Yes.

1 MR. KEARSE: Object to form, and
2 that's not what the document says, if you are
3 reading for the doctor.

4 MR. BOEHM: When I'm done with the
5 doctor, I'll be happy to ask you some
6 questions, but I think we got it on the record.

7 MR. KEARSE: You are reading the
8 document and you weren't reading it correctly.

9 MR. BOEHM: Unfortunately, I think
10 you listened to the lawyer and not the witness,
11 when he said yes to my question.

12 THE NOTARY: I was listening to
13 both of you.

14 MR. BOEHM: Not me. I wasn't
15 talking.

16 THE NOTARY: Do you want me to ask
17 the question again?

18 MR. BOEHM: I think it will be on
19 the recording, but I'll ask you, Anne, not to
20 speak when other people are speaking. This is
21 an instance where your interruption has caused
22 the court reporter not to have heard,
23 apparently, the answer that the witness gave,
24 and I don't want that to happen. It is
25 inappropriate. It shouldn't be happening at

1 all.

2 MR. KEARSE: Well, for the record,
3 I'm reading it right now, I said object to the
4 form --

5 MR. BOEHM: I don't need you to --
6 I don't want to -- I'm not asking you about
7 this document. I'm talking the matter of
8 procedure and process.

9 MR. KEARSE: Counsel, before he
10 answers and after you ask the question, I'm
11 allowed to says an objection.

12 MR. BOEHM: Object to form.

13 MS. KEARSE: And I did object to
14 the form.

15 And I'll ask the doctor, so if we
16 have time, I'm allowed to object before he
17 answers, the witness, Dr. Smith.

18 THE NOTARY: Question: "And it
19 breaks out the different means by which opiate
20 addicts were obtaining prescription opiates for
21 the year 2012 into different percentage
22 categories, right?"

23 A. So it does, it says how
24 prescription opiates are obtained, and
25 presumably that is by people with opiate

1 addiction.

2 Q. So the answer is yes, right?

3 A. Yes.

4 Q. Okay. And the first and largest
5 category here is 55 percent. It says, "Free
6 from a friend or relative"; do you see that?

7 A. Yes.

8 Q. What do you understand that to
9 include? That's a situation where the person
10 is receiving the prescription opioid not from a
11 healthcare provider, but from an individual who
12 already had the prescription drug, right?

13 MR. KEARSE: Object to form.

14 A. Right. So a friend or a relative
15 is handing them to the person who is probably
16 got an opiate addiction and has probably
17 figured out a way to ask them for it.

18 Q. And that's unlawful?

19 A. Yes.

20 Q. Okay. And the next category, it
21 says, "17 percent stolen from a friend or
22 relative"; do you see that?

23 A. Yes.

24 Q. And that's also unlawful, right?

25 A. Yes.

1 Q. And it says, "11 percent bought
2 from a friend or relative"; do you see that?

3 A. Yes.

4 Q. And that's also unlawful, right?

5 A. Correct.

6 Q. The next category says, "5 percent,
7 doctor prescription"; do you see that?

8 A. Yes.

9 Q. So this is saying that, at least
10 for the year 2012, only 5 percent of
11 prescription opioid medicines that were being
12 obtained for abuse were obtained directly
13 through a doctor prescription, right?

14 A. For abuse, so people with the
15 disease of addiction, yes, they were finding
16 other ways to get them.

17 Q. Okay.

18 A. Which is what an addicted person's
19 brain would lead them to do, is to break the
20 law, whatever they have to do to get that
21 substance.

22 Q. Right. But the point is here that
23 I'm making, is that only 5 percent of
24 prescription opioid medicines that were being
25 obtained for abuse were obtained directly

1 through a doctor prescription, right?

2 A. According to this, yes.

3 Q. And do you have any reason to
4 dispute this statistic?

5 A. No.

6 Q. Do you know how these percentages
7 changed after 2012?

8 A. I do not.

9 Q. Fair to say that -- okay. Let's
10 see. The fourth one says, "Drug dealer or
11 stranger, 4 percent"; do you see that?

12 A. I see that.

13 Q. That's the last one.

14 A. Yes.

15 Q. That's also unlawful, right?

16 A. Yes.

17 Q. So at least as of 2012, at least 95
18 percent of the prescription opioid medicines
19 that were being obtained for abuse were
20 obtained through some intervening unlawful
21 conduct on behalf -- on behalf of the -- on the
22 part of the drug seeker, right?

23 MR. KEARSE: Object to form.

24 A. That's accurate, but that
25 presupposes then that they had already had

1 prescription opiates, became addicted, and now
2 they needed to find a way to maintain their
3 addiction.

4 Q. I'm not presupposing anything. I'm
5 just looking at the statistic here.

6 A. But that's what the graph is about.
7 It's people who have developed addiction, and
8 we know that the vast majority start with
9 pills, now they are driven to get more pills.

10 So, yes, then in that respect, they
11 now need to seek other ways of getting those
12 pills.

13 Q. When you say, "The vast majority,"
14 okay, that's a separate topic, and I do want to
15 talk to you about that, but you're not
16 disagreeing with this graphic, right?

17 A. Correct.

18 Q. The subject of how people become
19 addicted is a complicated one; isn't it?

20 A. Not particularly complicated, no.

21 Q. Okay. You think addiction science
22 and addiction medicine is pretty simple?

23 A. I think that we understand enough
24 about how people getting addicted, they have a
25 brain reward system that is set up to like, for

1 lack of a better word, the substance more than
2 most. They try the substance, and they get
3 addicted.

4 I don't think there is a lot of
5 complications to that. I think that's pretty
6 straightforward.

7 Q. In fact, in the scientific
8 community, there is a huge amount of
9 complication to that, right? I mean, there is
10 a whole board certification process for
11 addiction medicine, right?

12 A. Well, the certification process is
13 about how to treat it. Treating it is much
14 more complicated, because now the brain is not
15 thinking with this part, it's thinking with
16 your animal brain. Not really thinking, it's
17 driven now to obtain, use or think about
18 obtaining and using the substance, and that's
19 the complicated part. Treatment is very
20 complicated.

21 Q. But the medical literature, doctor,
22 to be fair, to the extent you reviewed it,
23 makes it clear that the factors that play into
24 whether or not somebody is an addict naturally,
25 or is likely to become an addict, depending on

1 exposures to various substances, is, indeed, a
2 very complicated scientific question; do you
3 disagree with that?

4 MR. KEARSE: Object to form.

5 A. It is complicated in the sense that
6 we don't have a way yet to predict who may
7 become addicted to a given substance, so that
8 part is complicated.

9 The actual route to addiction is
10 very simple. You have to have a predisposition
11 to turn your reward system on more than most
12 people's reward system, and also you have to
13 actually take the substance in order to turn on
14 that reward system, and then you end up with
15 addiction.

16 - - - - -

17 (Thereupon, Deposition Exhibit 17,
18 October 10, 2017 Email From Caraffi,
19 with Attachment, Beginning with
20 Bates Label SUMMIT 906717, was
21 marked for purposes of
22 identification.)

23 - - - - -

24 Q. I'm going to show you the next
25 exhibit. It is marked as 17. And this is an

1 email -- it is one of these email chains from
2 October of 17, and like most email exchanges,
3 you kind of have to start at the bottom --

4 A. Right.

5 Q. -- to go in chronological order.

6 And the first email appears to be
7 from V. Caraffi on October 10, 2017.

8 MR. KEARSE: Counsel, I just -- I
9 suspect Dr. Smith' name is on here somewhere?

10 MR. BOEHM: Yes.

11 MS. KEARSE: Okay.

12 MR. BOEHM: I believe, Brad can
13 tell me if I'm wrong, but I believe this was
14 produced from his custodial file.

15 MR. MASTERS: Yes.

16 MR. KEARSE: I mean, it's a Summit
17 County number on it.

18 MR. BOEHM: There are, indeed,
19 many, many names on here.

20 MR. KEARSE: I know, and I'm going
21 to take your word for it right now, until I
22 actually look at it.

23 MR. BOEHM: Okay.

24 MS. KEARSE: I would assume that
25 you are suggesting that his name is on here?

1 MR. BOEHM: Yeah. There it is. I
2 found it.

3 MS. KEARSE: Okay.

4 Q. You know who V. Caraffi is?

5 A. Yes. So he runs the Cuyahoga
6 County Opiate Task Force, or did, at least, at
7 that time, I think he still does, and because I
8 had gone to some of their meetings in the past,
9 he added me to their distribution. So I do get
10 maybe not all, but certainly some of the emails
11 from their task force.

12 Q. So he sent you this email on
13 October 10, 17, along with scores of other
14 people?

15 A. Yes.

16 Q. And he writes, "Good morning,
17 please review the citation below sent on behalf
18 of Dr. Gilson"; do you see that?

19 A. Yes.

20 Q. Who is Dr. Gilson?

21 A. He is their medical examiner for
22 Cuyahoga County, just like Dr. Kohler is for
23 us.

24 Q. He reports in this email to you and
25 others, that, "At the April task force meeting,

1 Tom" -- is that Dr. Gilson?

2 A. Yes.

3 Q. "Tom indicated local data was
4 showing an increasing trend in the number of
5 overdose fatalities from heroin/fentanyl with
6 no history of overprescribing of pain
7 medication"; do you see that?

8 A. Yes.

9 Q. Are you familiar with these data?

10 A. Again, it's not Summit County data,
11 but I do read the emails that they send.

12 Q. My question is whether you are
13 familiar with these data that are being
14 referred to here in this email?

15 A. Only because he sent me the email.
16 No, not prior to that, I wouldn't have. He,
17 again, is for a different county.

18 Q. Has Summit County undertaken an
19 analysis to determine whether or not the number
20 of overdose fatalities from heroin and fentanyl
21 in Summit County are among individuals with no
22 history of overprescribing of prescription pain
23 medication?

24 MR. KEARSE: Object to form.

25 A. I don't know about a formal study.

1 When I've talked to Dr. Kohler on numerous
2 occasions along the way, that's never the
3 impression that she's given me; that generally
4 they are able to track backwards and find that
5 there were pills before there was dope.

6 Q. Okay. So here is some local data
7 that's saying that's not what's happening,
8 right?

9 A. From Cuyahoga County, yes.

10 Q. And you have not undertaken and you
11 are not aware of Summit County having
12 specifically undertaken an analysis to see
13 whether or not the trends in Cuyahoga County
14 are similar to trends in Summit County; did I
15 understand that right?

16 MR. KEARSE: Object to form.

17 A. Yeah. I'm not aware if Dr. Kohler
18 has done that. It wouldn't be something I
19 could even run. It's got to be done using the
20 death investigation files, but I don't know if
21 she has done one or not.

22 Q. You said a couple of times that
23 these people, they get addicted to prescription
24 opioids, and they move to heroin. That's not
25 always true, right?

1 A. No. The studies I have seen
2 though, it's 75 to 83 percent, different
3 studies, started with pills, but, yeah, there
4 is a certain small percentage, or smaller
5 percentage, at least, that started with street
6 drugs.

7 Q. What studies are you referring to
8 that mention the 75 to 83 percent?

9 A. Most recently, came out two days,
10 in the Journal of American Medical Association,
11 there is an article in there.

12 Q. Two days ago?

13 A. Two days ago.

14 Q. For what period of time is that
15 Journal of the American Medical Association
16 article looking back at to reach whatever
17 statistical figures it has provided?

18 A. I don't recall. I think it was an
19 update to an earlier article. It might have
20 been from 2013, so it may be one that goes all
21 the way back to the original date of 2012, or
22 something like that, but I don't recall.

23 Q. You don't know what period of time
24 is being referred to?

25 A. I just saw the highlights of it. I

1 mean, I have not read the whole article. I
2 just saw the highlights two days ago, so...

3 Q. So when you saw these statistics
4 and how likely it is or not that somebody first
5 became addicted to an opiate through
6 prescription, as opposed to heroin or fentanyl,
7 you are not sure what period of time those
8 statistics are based on?

9 MR. KEARSE: Object to form.

10 A. Well, so when they -- when they do
11 studies like this one that Dr. Gilson did, then
12 they are looking at their entire lives, because
13 that's what they do in death investigation
14 reports. So they would know exactly -- they
15 would go back their whole life and try to
16 figure out if they ever had opiate pills, and
17 if that was the trajectory.

18 So in that case, it would be
19 whatever their lifespan was. It wouldn't be a
20 matter of, "Oh, we started in 2012." It would
21 be how long was Mr. Jones -- we looked at their
22 whole history, and we said, "Oh, Mr. Jones had
23 sprained his ankle playing soccer, and here is
24 what happened."

25 Q. But I presume these articles and

1 these statistics are not based on anecdotal
2 cases like Mr. Jones's, right?

3 They're based on more
4 population-wide statistical inputs, I would
5 presume; am I wrong?

6 A. I'm sure they are based on
7 aggregate data, but it may have required them
8 to go back in time and figure out via the
9 people.

10 Q. And I'm asking you whether or not
11 you know what period of time was looked at, for
12 purposes of generating these statistical
13 outputs? I mean, surely they adopted some
14 parameters in that regard, and I'm asking you
15 whether or not you know?

16 MS. KEARSE: Object to form.

17 A. Right. And I said the one I'm most
18 familiar with recently is JAMA, and I don't
19 recall what the time frame was.

20 Q. Do you know the time frame for any
21 of the articles that set forth a statistic
22 purporting to identify whether or not
23 individuals became first addicted to
24 prescription opioids or whether to an illicit
25 street opiate substance?

1 A. Sitting here today, I don't recall.

2 Q. This JAMA article that you
3 mentioned as having come out a couple of days
4 ago, do you know whether or not it encompassed
5 Summit County data?

6 A. Again, I only saw the little
7 abstract, so I don't know.

8 Q. Was it particular to Summit County,
9 Ohio?

10 A. No. It was not specifically
11 created for Summit County.

12 Q. Are you familiar with any
13 peer-reviewed article that provides estimates
14 of how addicted patients first became addicted
15 in Summit County?

16 A. No. I don't think so I've seen any
17 publications that are rigorous research, no.

18 Q. And you mentioned, I think, you
19 have had conversations with people in Summit
20 County about what those percentages might be.
21 Did I hear you right?

22 A. Not just people, with Dr. Kohler
23 and her office is the one that would make those
24 determinations.

25 Q. Do you know the specific process or

1 procedure or statistical protocol, if any, that
2 Dr. Kohler implemented, in terms of trying to
3 reach conclusions about those statistics?

4 A. I do not.

5 Q. Okay. But here there is, at least,
6 some data suggesting that it is more likely
7 for, at least, some periods of time that an
8 individual became addicted or initiated opiate
9 use through heroin than through prescription
10 opioid medications, right?

11 MR. KEARSE: Object to form.

12 A. No. These are all below 50
13 percent, so it's -- even these articles say it
14 is more likely to be pills.

15 Q. Well, let's read it together and
16 see if that stands up. If you look in the
17 Results section here, do you see Results?

18 A. Yes.

19 Q. It say, "The use of commonly
20 prescribed opioids, oxycodone and hydrocodone,
21 dropped from 42.4 percent and 42.3 percent of
22 opioid initiators, respectively, to 24.1
23 percent and 27.8 percent in 2015"; do you see
24 that?

25 A. Yes.

1 Q. "Such that heroin as an initiating
2 opioid was now more frequently endorsed than
3 prescription opioid analgesics"; do you see
4 that?

5 A. I do. Okay.

6 Q. What is your understanding of that?

7 A. Okay. So you are right. So their
8 conclusion is that people started with heroin.

9 Q. Has the Summit County ADM Board or
10 anybody else in Summit County ever undertaken
11 an evaluation or an analysis to determine
12 whether or not these statistics would be true
13 within Summit County?

14 A. Let me read the conclusions first.

15 So, no, I don't think we've -- I've
16 not seen statistics in Summit County, but I
17 think the conclusions make a pretty strong
18 statement, which is that because we have
19 decreased the overprescribing of hydrocodone
20 and oxycodone, that it stands to reason that
21 more and more people might start with something
22 other than prescription opiates. I don't think
23 that's rocket science.

24 Q. It stands to reason that some
25 people -- they've never even tried a

1 prescription opioid, they would go right to
2 heroin; is that what you are saying?

3 A. That there are some -- there are
4 always going to be some people who are going to
5 try whatever is out there to feel differently,
6 and there obviously are -- this may be
7 representing the people, in fact, it may be a
8 very positive sign that we have pushed back
9 the -- overflowing the market with pills.

10 That, at least, leaves us with the
11 only -- in quotes, the other half in the
12 problem, which is to treat all the people for
13 the next number of decades for their addiction.

14 Q. When you say there is always going
15 to be some people who are going to try whatever
16 is out there, tell me what you mean by that?

17 A. Well, psychiatrically, there are
18 people who don't like how they feel, and they
19 will snort, inhale, inject, skin pop, anything
20 they can get their hands on, in order to feel
21 differently, maybe hoping to feel better.

22 Some people do that by jumping off
23 a bridge in a bungee cord or SCUBA diving or
24 some other way of getting their rush. Others
25 will try substances.

1 Q. And there is a certain segment of
2 the population who is just predisposed to that
3 kind of dangerous behavior; is that what you
4 are saying?

5 MR. KEARSE: Object to form.

6 A. Yeah. There is a small percentage
7 of people who will do that, which, I think,
8 accounted for the original, although far
9 smaller heroin epidemic way back in the 70s.
10 That was just a very small segment that had
11 that path.

12 Q. There is a follow-up email from
13 somebody named Thomas Tallman. Do you know
14 who -- by the way, is that a doctor?

15 A. I honestly don't know who that is.

16 Q. You don't know who that is. He is
17 at MetroHealth. Do you know what MetroHealth
18 is?

19 A. Yes.

20 Q. Is that a hospital?

21 A. That is a hospital in Cleveland.

22 Q. But you are not familiar with Dr.
23 Tallman. Okay.

24 He writes, in response to this
25 email from Mr. Caraffi, "I can also add that a

1 significant number of inmates I have screened
2 for Vivitrol MAT do not have a history of
3 opioid addiction following a prescription for
4 Percocet, OxyContin, et cetera"; do you see
5 that?

6 A. I see that.

7 Q. So he is further substantiating
8 these statistics that suggest that actually
9 people maybe are initiating with
10 nonprescription opiates, street opiates, rather
11 than initiating with FDA-approved prescription
12 opioid medications, designed for legitimate
13 medical use, right?

14 MR. KEARSE: Object to form.

15 A. It appears that's what he's saying;
16 although, having worked in the prison setting
17 in the past myself, I would doubt the veracity
18 of many of the people who are giving me the
19 information, and I'm sure he's got no other
20 controls on that, so that saying, "Oh, yeah, I
21 went out one day and snorted heroin, as opposed
22 to doctor so and so gave me."

23 So, you know, yes, he seems to be
24 supporting, but I don't know that I would -- I
25 would put more stock on this study than I would

1 on the --

2 Q. Well, he's saying his experience
3 confirms the findings of the study, right?

4 MR. KEARSE: Object to form.

5 A. Yeah. He seems to be wanting to
6 support it, based on his anecdotal information,
7 yes.

8 Q. And with respect to the reliability
9 of self-reporting by addicted patients, that's
10 the basis for all of these statistics, isn't
11 it? They are actually just asking addicted
12 patients how they initiated opiate use?

13 MS. KEARSE: Object to form.

14 A. No. I believe when medical
15 examiners do it, they look back at OARRS, and
16 so forth, to find out if the person actually
17 received prescriptions for opiates.

18 Q. How would that tell them whether or
19 not they first had heroin, just because it is
20 in OARRS?

21 How do you know, based on looking
22 at OARRS, that somebody got a prescription,
23 they didn't have heroin first --

24 MS. KEARSE: Object to form.

25 Q. -- that doesn't answer that

1 question, does it?

2 A. No, I agree. That wouldn't fully,
3 100 percent, answer the question, but...

4 Q. So if you are relying on OARRS data
5 alone to try and derive statistics about how
6 somebody initiated opiates, you might be on a
7 mission to nowhere, fair?

8 MR. KEARSE: Object to form.

9 A. I think it depends on the patient.
10 If it's a 17-year-old high school hockey player
11 who twisted her ankle and had opiates, it's
12 pretty fair to assume she didn't use heroin
13 when she was 12.

14 Q. Sure. Or if it is a 27-year-old,
15 and you see that there is some prescription
16 along the way, you can't determine whether or
17 not that was their initiation to opiate abuse,
18 right?

19 A. Not 100 percent, no.

20 Q. Okay. And, likewise, if you are
21 looking at information that's gleaned from
22 toxicology reports in the medical examiner's
23 office, and you see that there is certain
24 substances present or not present, you can't
25 learn from that information what that

1 particular individual initiated, in terms of
2 their opiate use, correct?

3 A. From one tox screen, no.

4 Q. All right. Let's move to the next
5 exhibit, which I'm going to mark as Exhibit 18.

6 - - - - -

7 (Thereupon, Deposition Exhibit 18,
8 May 2015 Email Exchange, Beginning
9 with Bates Label SUMMIT 834829, was
10 marked for purposes of
11 identification.)

12 - - - - -

13 Q. This is an email exchange that you
14 were involved in, it goes back to May 2015, and
15 it starts on May 22, 2015. It was sent by
16 Janet Shaw.

17 A. Uh-huh.

18 Q. Is that a physician?

19 A. No.

20 Q. Who is Ms. Shaw?

21 A. She is the administrative director
22 for the Ohio Psychiatric Physicians
23 Association.

24 Q. Okay. And she writes to a group of
25 individuals, including you, and says that,

1 "Representative Sprague's office called us
2 today to schedule a meeting to discuss four
3 bills and the," quote, "concept paper for
4 another bill that Representative Sprague is
5 having drafted to specifically address
6 behavioral health"; do you see that?

7 A. Yes.

8 Q. And she addresses this to Members
9 of the Public Mental Health Committee and
10 Members of the Government Relations Committee;
11 do you see that?

12 A. Yes.

13 Q. Were you a member of one or both of
14 those committees?

15 A. Public Mental Health Committee,
16 yes.

17 Q. What is the Public Mental Health
18 Committee?

19 A. It is a group of psychiatrists who
20 are members of the OPPA, who tend to work in
21 the community or public mental health arena,
22 and are interested in discussing ideas and
23 thoughts.

24 Q. Are you still on the public
25 health -- I'm sorry, the Public Mental Health

1 Committee?

2 A. Yes, I am.

3 Q. So she sends this information to
4 you and others who are on these committees,
5 right?

6 A. Yes.

7 Q. And then a gentleman by the name of
8 Mark Munetz responds?

9 A. Yeah. Dr. Munetz.

10 Q. Dr. Munetz, okay. He's at NEOMED?

11 A. He's the chair of psychiatry at
12 NEOMED, yes.

13 Q. Is that somebody -- is Mark
14 somebody that you know?

15 A. Yeah. He was in my position at ADM
16 for about 20 years, before he shifted.

17 Q. Okay. And then on top of Dr.
18 Munetz's email, somebody by the name of Eileen
19 McGee weighs in; do you see that?

20 A. Yes.

21 Q. Who is Eileen McGee?

22 A. She is another psychiatrist that I
23 know by phone, but not in person.

24 Q. And then Dr. McGee writes, and
25 toward the end of her email she says, with

1 respect to two of the bills, "The other two
2 seem overly intrusive into the practice of
3 medicine and very punitive. If I read the one
4 correctly, any opioid would require prior
5 authorization, so if you are going to break a
6 major bone, you better plan to do it?"; do you
7 see that?

8 A. I see that.

9 Q. In other words, she is expressing
10 concern about this draft legislation that would
11 place restrictions on individual healthcare
12 providers' discretion to prescribe an
13 FDA-approved opioid medicine when that doctor
14 believes it is in the best interest of an
15 individual patient, right?

16 MR. KEARSE: Object to form.

17 A. Right, and again, without the
18 attachments here, it's a little bit tougher,
19 but, yes, apparently whatever the bill said,
20 the fear was it would be overly restrictive to
21 allow -- getting people to be able to get pain
22 meds when they had legitimate pain, like a
23 broken bone.

24 Q. And your position here and
25 historically has been you shouldn't -- you

1 shouldn't -- you shouldn't create incentives
2 for doctors to overprescribe when it's not in
3 the patient's best interest, nor should you
4 create a situation where doctors feel compelled
5 not to prescribe an opioid medicine when it is
6 in the patient's best interest, right?

7 A. Correct.

8 Q. And she's expressing concern about
9 that very same thing, right?

10 A. Yes.

11 Q. And you write in, to say, "I agree
12 with the comments from Mark, Eileen and Steve
13 Jewell," and the last sentence of the first
14 paragraph, you write, "I am concerned about
15 Sprague's strong limits on docs for opiate
16 prescribing, and that issue is not part of any
17 of the other discussions"; do you see that?

18 A. I see that.

19 Q. Did I read it correctly?

20 A. Yes.

21 Q. What were you saying, when you
22 expressed concern about Representative
23 Sprague's strong limits on doctors for opiate
24 prescribing?

25 A. Without seeing the attachments, I

1 can't give you any specifics.

2 Q. Does this sound familiar to you?

3 A. Yeah, it certainly sounds familiar.
4 Yeah, it sounds familiar, but it has been over
5 three years, and I would want to see the
6 proposed bill before I can tell you what I
7 fully meant about that.

8 Q. Okay. To the extent that any
9 individual representative or committee was
10 advancing legislation that would limit an
11 individual healthcare provider's discretion to
12 prescribe an opioid medicine to a patient when
13 it was, in that doctor's view, in the best
14 interest of that patient, you would not favor
15 that particular policy or legislation; is that
16 fair?

17 MR. KEARSE: Object to form.

18 A. So I think I have to put my answer
19 in context. You know, the problem is that, in
20 effect, the way we were feeling, still are
21 feeling, although it's getting better, even
22 though we know we have got years of treatment
23 of these individuals ahead of us, is that we
24 are in the middle of people dying left and
25 right, and everybody, every branch of

1 government, every clinician of many types, is
2 trying to figure out, how do we stop people
3 from dying needlessly from opiate death
4 overdoses.

5 And so what you have got, and
6 here you've got -- we had millions -- not
7 millions -- probably literally, though,
8 hundreds of bills being proposed about what
9 this representative, or that representative, or
10 the governor, or law enforcement, or the
11 attorney general, wanted do to try to solve
12 this.

13 And so our difficulty was, wow, you
14 know, we get it. People are dying, we
15 got -- let's stop, let's eliminate all opiates.
16 It was, kind of like, well, that doesn't work
17 if you are physician, because we also are doing
18 this to help people.

19 So I think that's the -- so in that
20 context, this is one out of probably many
21 discussions that we have had, you know, because
22 the different bills or different things.

23 We shut down the pill mills, and
24 that was a good thing to do, because we had to
25 stop those, in those case, criminal physicians

1 from adding to the problem by putting more
2 pills out there. On the other hand, those
3 individuals now have addiction, and they are
4 going to go find their pills somewhere.

5 So these are all balances, but we
6 are in the middle of what felt like a war zone,
7 and causes us to have these discussions, and
8 how do you come up with the right answer.

9 Q. Got it.

10 And there were some proposals that,
11 in the view of you and other doctors, that went
12 too far, in terms of restricting the use of
13 opiates, or at least restricting an individual
14 doctor's discretion to do what was best for a
15 patient in a particular circumstance; is that
16 fair?

17 A. Fair. That bill did not go
18 forward, because we don't have that law now,
19 so...

20 - - - - -

21 (Thereupon, Deposition Exhibit 19,
22 March 2017 Email Exchange, Beginning
23 with Bates Label SUMMIT 887987, was
24 marked for purposes of
25 identification.)

1		-	-	-	-	-
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2 Q. This is Exhibit 19. This is
3 another email that you were a part of, an email
4 exchange, I should say, that started in March
5 2017, and ultimately got forwarded to you a few
6 days later.

7 It starts with an email from Margie
8 Munn to Carol Baden; do you see that?

9	A.	I do.
---	----	-------

10 Q. Do you know who Carol Baden is?

11 A. I do not.

12 Q. This individual writes about the
13 suffering and the pain that she is
14 experiencing, and she says that she is at the
15 end of her rope; do you see that?

16	A. Yes.
----	---------

Q. She says, "My daily activities have diminished even more, and I am barely existing. I am very discouraged. I have just about given up on ever having a life and would much rather not be here to endure the pain. Not only is it physically, but it is so mentally exhausting, has affected my relationships with everyone. I now have become a recluse. Please hear my desperation and please help"; do you see that?

1 A. I see that.

2 Q. Do you recall this email?

3 A. I don't specifically recall this
4 one, but...

5 Q. What do you understand this person
6 to be saying?

7 A. Well, it appears that she believes
8 she is in extreme physical pain and apparently
9 is not getting the relief she needs.

10 Q. And Ms. Baden is concerned enough
11 about this woman and what she's experienced
12 that she refers the situation to members of the
13 Summit County ADM Board. You can look back to
14 see that.

15 First, it goes to Mr. Jerry Craig;
16 do you see that? If you go to 7989 in the
17 bottom right-hand corner, you can see the
18 continuation of the conversation.

19 A. Yes. I see that Jerry Craig sent
20 her an email, okay.

21 Q. On March 4, Jerry Craig sends this
22 individual an email, learns that she lives in
23 North Benton, they have a conversation, and
24 then, later that night, this individual writes
25 to Mr. Craig; do you see that?

1 A. Yes.

2 Q. And she describes her experience in
3 more detail. She says she has had two major
4 surgeries, she has had every injection that she
5 is aware of, physical therapy makes her
6 situation worse, right?

7 A. Yes.

8 Q. She writes, "I understand the point
9 of doctors overprescribing and all of the
10 deaths, but there are some of us that need
11 medication to have some sort of quality of
12 life. There are no more surgeries to help me.
13 My highly qualified surgeon at The Cleveland
14 Clinic said further surgeries will not help me.
15 There are more overdoses because the government
16 thinks they have the right to tell a doctor how
17 to treat patients' pain. They simply are
18 afraid of losing their licenses, and it is not
19 fair to the doctor or the patient who follows
20 the rules. I had to sell my home because I
21 couldn't walk up the stairs. Some days I
22 cannot get out of bed, and just to take a
23 shower is a chore"; do you see all that?

24 A. Uh-huh.

25 Q. She writes, "If you have

1 suggestions or ideas, I'm very open to them,
2 but under no circumstances do I want to be
3 labeled as a drug addict or drug seeker,
4 because I am not. I just want to live the rest
5 of my days at least being able to hold my
6 grandchildren, get up in the morning, and be
7 able to maintain a life without pain"; do you
8 see that?

9 A. Yes.

10 Q. Do you think this woman from North
11 Benton is a drug addict?

12 A. I have no idea.

13 Q. Do you think that this woman from
14 North Benton who wants to hold her
15 grandchildren and walk up the stairs is a drug
16 seeker, as that term is used in an pejorative
17 sense?

18 MS. KEARSE: Object to form.

19 A. Again, not knowing her, it could be
20 either direction. This could be an addiction
21 talking, and she could have been thwarted at
22 all turns to get further prescription
23 medications to feed her addiction, and now she
24 is reaching to, it looks like, the attorney
25 general, who then referred her back to ADM.

1 If you can sell your parents' TV
2 set or car for drugs, you can write emails that
3 sound like you need help.

4 Q. Yeah. And you can also be somebody
5 who wants to hold your grandchildren, but
6 can't, because you are suffering from severe
7 chronic pain that does not respond to anything
8 but opiate medications, right?

9 MR. KEARSE: Object to form.

10 A. Yes, that's also possible.

11 Q. And if you keep going up the chain
12 of the email, Mr. Craig now loops you in; do
13 you see that?

14 A. Yes.

15 Q. He says, "I'm trying to find a
16 gentle way to pass this woman along to a
17 resource that offers information about pain
18 management programs." And Mr. Craig is telling
19 you he's looking for a way to pass this woman,
20 who is from North Benton, to other resources
21 and he wants to bow out, correct?

22 A. Correct, because we are not in the
23 specialty of treating pain, correct.

24 Q. And you provide a list of actual
25 pain clinics, right?

1 A. In Mahoning County, right, because
2 it turns out she is elsewhere.

3 Q. And you provide a reference,
4 though, to some pain clinics?

5 A. Correct.

6 Q. Were any of those pain clinics, in
7 your view, pill mills?

8 A. No. These were legitimate ones,
9 and it happened that my small private practice
10 of Worker's Comp patients, three days a month
11 is Lake County, and one day a month is Mahoning
12 County, so I knew where to find the legitimate
13 pain clinics.

14 So our goal was to help her, but
15 you can see Mr. Craig says, it turns out it
16 wasn't a mental health issue, it was a pain
17 issue. Well, we are not experts in treating
18 pain, so we wanted to make sure we gave her the
19 care she needed, and I believe that worked,
20 because I think one of our adult liaisons
21 reached out, and she got what she needed.

22 Q. She got the pain treatment she
23 needed, it turned out that she was not an
24 addict?

25 A. I don't know. She got the

1 treatment she needed. I don't know what
2 treatment she got.

3 Q. You don't know any details about
4 it?

5 A. I do not.

6 Q. Jerry writes to you, at the very
7 top of this email chain, saying that, "This is
8 outside your expertise," right?

9 A. Correct, meaning pain management.

10 Q. So you are looking at this
11 situation from one side of the equation, from
12 the addiction side of the equation, but your
13 area of expertise is not the pain management
14 side of the equation, right?

15 MR. KEARSE: Object to form.

16 A. So I looked at this as a person who
17 neither Jerry or I could see or evaluate, and
18 somebody that, therefore, we would take
19 seriously and try to get her to somebody who
20 could actually see her in person and determine
21 what she need.

22 Q. And that's terrific, but I'm
23 referring specifically to the language
24 specifically, "Outside of our expertise," and I
25 think you said earlier pain management is

1 outside of your expertise --

2 MR. KEARSE: Object to form.

3 Q. -- right?

4 A. Correct. None of us at ADM are
5 pain experts.

6 Q. So when you are looking at the
7 situation of the use of opiates and
8 particularly prescription opioid medications,
9 you are coming at it from an addiction
10 perspective, you are not coming it from an
11 expertise in pain management; is that fair?

12 A. Yes.

13 - - - - -

14 (Thereupon, Deposition Exhibit 20,
15 September 24, 2015 News Release From
16 the Ohio Department of Health, was
17 marked for purposes of
18 identification.)

19 - - - - -

20 Q. This is Exhibit 20. It is a
21 September 24, 2015 news release from the Ohio
22 Department of Health; do you see that?

23 A. Yes.

24 Q. This news release reports that Ohio
25 has seen a major increase in drug reports

1 involving fentanyl; do you see that?

2 A. Yes.

3 Q. And we talked about fentanyl a
4 little bit earlier, as coming from -- typically
5 coming from China and being used, and it can be
6 very dangerous, right?

7 A. Very dangerous.

8 Q. It says about two-thirds down the
9 page, "Since Ohio started to aggressively fight
10 back against opiate abuse, the state has begun
11 seeing some promising progress"; do you see
12 that?

13 A. Yes.

14 Q. And then it describes some of the
15 progress that Ohio has seen?

16 A. Uh-huh.

17 Q. Now, do you know, when this press
18 release from the Ohio Department of Health
19 refers to the state having begun to fight back
20 aggressively against opiate abuse, do you know
21 what period of time they are referring to?

22 A. Well, it says beginning in --
23 "Building on efforts that started in 2011," in
24 the paragraph above.

25 Q. And that would have been just a few

1 months after Governor Strickland's Opiate Task
2 Force released its conclusions in October 2010,
3 right?

4 MR. KEARSE: Object to form.

5 A. Yeah, it appears that way. Yes.

6 Q. The first bullet point says, "The
7 number of opiate prescriptions had decreased by
8 40 minimum doses"; do you see that?

9 A. Yes.

10 Q. Why did that number go down?

11 A. Because there was a lot of
12 discussion about people dieing from overdose
13 deaths, physicians were gradually being
14 educated about it, and it represents that there
15 clearly were way too much pills being dispensed
16 from pharmacies all across the state, and they
17 got -- they started to drop, and they have
18 continued to drop, since that time, actually.

19 Q. So you mentioned physician
20 education --

21 A. Uh-huh.

22 Q. -- as one way that that number went
23 down?

24 A. Right.

25 Q. Anything else that you think

1 explains why the number of opiate prescriptions
2 decreased?

3 A. Sure. OARRS was in use, and then
4 became mandatory. Lots of -- so there is those
5 kind of pieces.

6 The eduction, the OARRS, somewhere
7 in that time frame, I don't remember the exact
8 dates, they may have shut down the pill mills,
9 so that may have taken some of the pills out of
10 the equation, but a lot of it was about
11 physician education.

12 There were -- I mentioned before,
13 there were guidelines placed in emergency
14 departments, so that the -- any patient coming
15 in, again, even somebody with an addiction
16 would immediately see they are not going to
17 get, which at its peak might have been a 30-day
18 supply, a 90-day supply, when this was really
19 rampant.

20 Now they are going to get maybe
21 zero, maybe a day. They can't come in and
22 complain they have tooth pain and get two weeks
23 to get to their dentist. They are going to get
24 two days and a dental referral, and the doctors
25 were given the same guidelines, which is the

1 perfect way to do it, because now I can easily
2 say to the patients, "Sorry, you saw the
3 placard, I can't give you more," and there is
4 no battle.

5 "Well, doctor, I heard somebody got
6 seven last week."

7 "Well, no, I'm sorry, they didn't,
8 because that's against the rules." That's how
9 that plays.

10 So there are a lot of ways that we
11 were pushing, because, again, at that point in
12 time, it was very clear that it was the
13 overabundance of pills out in Ohio that was the
14 root cause of the opiate overdoses. So we
15 needed to push that number down.

16 Q. When you say about these guidelines
17 in emergency departments, who was issuing these
18 guidelines?

19 A. I believe those came through the
20 Ohio Department of Health, so it was a
21 statewide initiative, and I'm sure that ODMHAS
22 had a role in that as well, you know, with
23 their expertise.

24 Q. Anything else? In terms of -- you
25 have mentioned physician education, OARRS,

1 shutting down pill mills, and prescribing
2 guidelines that were modified.

3 A. Uh-huh.

4 Q. Are there other reasons why, in
5 your view, and in the view of the Summit County
6 ADM Board, this number of opiate prescriptions
7 decreased?

8 A. Well, I mean, part of it, at that
9 point, might have been not only physicians
10 using OARRS, perhaps even the pharmacies
11 started using it more effectively. So that,
12 therefore, they were able to catch some of
13 that. Prior to that, I don't think they were
14 using OARRS effectively.

15 Q. So OARRS can have value both in the
16 clinical setting with the doctor, and in the
17 pharmacy setting with the pharmacist, right?

18 A. Correct.

19 Q. Anything else?

20 A. Not at the moment that I can think
21 of, no.

22 Q. The second bullet point there
23 refers to doctor shopping. We have talked
24 about that, and it also references OARRS?

25 A. Yes.

1 Q. And it says the doctor shopping had
2 decreased significantly, right?

3 A. Yes.

4 Q. Why did doctor shopping decrease?

5 A. Basically, it was very difficult
6 for patients to do it. As of this point, you
7 are going to get caught, if you go to more than
8 one doctor and that gets flagged on OARRS,
9 again by the physician, by the pharmacy, and, I
10 think by now, my guess is, the numbers dropped
11 to close to zero, because it was really hard to
12 pull off once it went -- once it became
13 mandatory. On April 1 of 15, that number of
14 960 probably dropped down to very, very few.

15 Q. Okay. Anything else that would
16 explain why doctor shopping was reduced?

17 A. That's the main -- that was the
18 purpose of OARRS, and that was -- it is very
19 effective for that.

20 Q. The third bullet point refers to
21 higher dosages of prescription opiate medicines
22 being prescribed to patients, and saying that
23 the volume of higher dosage prescriptions had
24 also been reduced; do you see that?

25 A. Yes.

1 Q. Why did that go down?

2 A. Well, it says it right here, "When
3 Ohio's opiate prescribing guidelines were
4 announced," so it was a reaction to the
5 guidelines, which again really has a twofold
6 effect, that is, that now physicians are on
7 alert, but it gives the physician a tool to say
8 to the patient, "Hey, you know what, I got this
9 guideline, and I got to follow this, and I'm
10 sorry, I can't give you that dose that you are
11 seeking."

12 And as much as their addiction
13 would probably get them sometimes to get pretty
14 angry about it, at least what is remaining
15 about their thought process, they can get to
16 that easier than just, "Oh, it is just the
17 doctor being mean to me today."

18 No, there is a guideline, and
19 that's the way the rules are, so that's a very
20 effective approach for two reasons, not just
21 one reason.

22 Q. Okay. Great. Then the fourth
23 bullet point, and last one on this page, refers
24 to the percentage of opiate prescribers who are
25 registered to use the OARRS database, and that

1 that number had gone up; do you see that?

2 A. Yes.

3 Q. Why did that number go up?

4 A. I believe that -- I don't know
5 when, when it was official. Again, as a
6 psychiatrist, I wasn't prescribing opiates,
7 which was the real purpose of OARRS, even
8 though it does have all the controlled
9 substances in it.

10 I don't recall the state hospitals
11 even being aware that OARRS existed, even
12 though, you know, it may have.

13 So I think once it got promoted,
14 including my own conference in May, we were now
15 telling doctors, "Hey, this tool exists. You
16 really ought to sign up for it."

17 I mean, doctors don't want to hurt
18 people. Doctors want to help people. So
19 doctors started signing up even without it
20 being mandatory. "Oh, my gosh, I could have
21 done that. I'll sign up." So I don't think it
22 was surprising that we would start to see an
23 increase in enrollment in that.

24 Q. And that ended up being helpful, in
25 terms of limiting doctor shopping and

1 drug-seeking behavior from addicted
2 individuals, right?

3 MR. KEARSE: Object to form.

4 A. Yeah. I mean, it stopped as many
5 pills and high doses as -- from flowing, as
6 there were before.

7 Q. Okay. I think that was 20, right?

8 A. Yes.

9 Q. So we will go to 21.

10 MR. BOEHM: I'm sorry.

11 MR. KEARSE: My question was at a
12 break, I would love, just for curiosity sake,
13 how long we have on the record.

14 MR. BOEHM: Oh, we have so much
15 time.

16 MR. KEARSE: I know we do. I just
17 was curious. I said, "At break, just for
18 curiosity."

19 MR. BOEHM: I'm feeling no
20 constraint whatever right now.

21 MR. KEARSE: I'm not asking you to.

22 MR. BOEHM: I'm joking.

23 MR. KEARSE: I said, "For curiosity
24 sake."

25 - - - - -

1 (Thereupon, Deposition Exhibit 21,
2 2015 Ohio Drug Overdose Data Summary
3 From the Ohio Department of Health,
4 was marked for purposes of
5 identification.)

6 - - - - -

7 Q. Okay. Dr. Smith, this document has
8 been marked as Exhibit 21, for purposes of your
9 deposition, and it is a 2005 Ohio Drug Overdose
10 Data Summary From the Ohio Department of
11 Health; do you see that?

12 A. 2015, yes.

13 Q. I'm sorry. Did I misstate that? I
14 said 2005. Thank you for the correction.

15 MS. KEARSE: And I was asleep at
16 the wheel, so thank you.

17 MR. BOEHM: Hey, this a witness --
18 he's on top of it. You can?

19 THE WITNESS: I'm trying.

20 MR. BOEHM: Yeah. No need to
21 worry.

22 MR. KEARSE: I'm not.

23 Q. Okay. Is this the kind of document
24 that you would receive, as part of your
25 professional duties as the clinical

1 director -- the medical director and chief
2 clinical officer for the Summit County ADM
3 Board?

4 A. Yes. It is representative of the
5 kind of data we were always trying to get,
6 sure.

7 Q. Okay. If you turn to the second
8 page here, at the top, it says that, "Although
9 pharmaceutical fentanyl may be diverted for
10 abuse in the U.S., the majority of fentanyl
11 drug reports and fentanyl reported with other
12 drugs result from illegally produced and
13 tracked fentanyl, not diverted pharmaceutical
14 fentanyl;" do you see that?

15 A. Yes.

16 Q. And I think that's consistent with
17 what you were saying earlier, that the
18 overwhelming majority of the fentanyl that's
19 making its way onto the streets for abuse is
20 illegally produced and trafficked, not
21 pharmaceutical, right?

22 A. Correct.

23 Q. Do you know what the percentages
24 are, in terms of the illegally produced and
25 trafficked fentanyl, versus the prescription

1 fentanyl?

2 A. I don't know the percentages. I
3 know the percentage of prescription fentanyl is
4 very low, because when they run -- they looked
5 at like -- because to get prescription fentanyl
6 diverted, it would be diverted from a hospital.
7 They can watch -- they can track that, and they
8 are showing that that's where it's coming from.

9 Q. And around this time, Ohio was
10 seeing an increase in drug reports involving
11 fentanyl, right?

12 A. That's correct.

13 Q. In your view, what accounted for
14 the increased incidence of drug reports
15 involving fentanyl?

16 A. Well, so as we worked hard to get
17 rid of the pills, and again, but we still have
18 these individuals with addiction to deal with,
19 their brain is going to make them find an
20 opiate, and if that means they have to go to
21 the street, they are going to go to the street,
22 and likely they went to the street, and they
23 think they are getting heroin, but they are
24 getting heroin plus fentanyl, sometimes just
25 fentanyl.

1 Q. And why is fentanyl making its way
2 into heroin that people might purchase on the
3 street?

4 A. A weird version of drug dealer
5 capitalism, is my thought.

6 Q. What do you mean by that?

7 A. So the drug dealers, in this opiate
8 epidemic, unlike the movies, we are not hearing
9 about a bunch of people shooting each other
10 because you're in my territory or they're in
11 somebody else's territory, which is, kind of,
12 how the movies portray it.

13 We have drug dealers who are
14 attempting to make more money by giving better
15 customer service and, in quotes, better
16 product. To a person with the disease of
17 addiction, the better product is the more
18 potent opioid product.

19 So if I want to outdo you as a drug
20 dealer, I'm going to try to find a friend of a
21 friend of a friend and add a stronger opiate to
22 my heroin and outsell you.

23 Q. That's what you mean by drug dealer
24 economics?

25 A. I didn't say that phrase but --

1 Q. I thought you did. Maybe I misread
2 it. You said drug dealer something?

3 A. Capitalism.

4 Q. Capitalism, drug dealer capitalism.

5 If you turn to the next page of
6 this document that has been marked as Exhibit
7 21, do you see right there in the middle of the
8 page, it says, "Number of heroin overdose
9 deaths increased," and this is for 2015, right?

10 A. Yes, I see that.

11 Q. And then just below that, it says,
12 "Prescription opioid overdose deaths declined";
13 do you see that?

14 A. Yes.

15 Q. And then there is a figure 4, which
16 is a graph that tries to depict the declining
17 prescription opioid overdose deaths and the
18 increasing overdose with heroin and fentanyl,
19 right?

20 A. Yes.

21 Q. And it looks, in fact, like the
22 number of opioid deaths related to prescription
23 opioid use or abuse is steadily dropping since
24 2010, right?

25 A. Yes. It looks like it is, yep.

1 Q. And the numbers for heroin and
2 fentanyl are going up, right?

3 A. Yeah. Fentanyl in particular.
4 Heroin kind of peaked, yes.

5 Q. Yeah, heroin kind of peaked, but
6 fentanyl keeps going up, right?

7 A. Yes.

8 Q. And, in fact, it looks like, if you
9 look over a few columns to the cocaine
10 category; do you see that?

11 A. Yes.

12 Q. The number of overdose deaths
13 related to cocaine and prescription opioids,
14 about the same, right, for 2015?

15 A. Oh, yes.

16 Q. Why is cocaine usage going up?

17 A. You know, historically, if you look
18 at trends across the country, as far as street
19 drugs go, they wax and wane in whatever reason
20 popular. I don't think it is clear why it is
21 cocaine now or originally heroin back in the
22 70s or crack cocaine during the 80s. That
23 seems to wax and wane, so it comes and goes,
24 and cocaine may go up when methamphetamine
25 drops, and then they will switch.

1 Q. Is that related to what you were
2 saying earlier, about how there is going to be
3 some segment of the population out there that
4 is just going to use whatever is available?

5 A. Yes. There is a certain
6 percentage, if they go down the path of trying
7 a substance or many substances, they are likely
8 to find the one that turns their brain on to
9 addiction.

10 Q. Okay.

11 - - - - -

12 (Thereupon, Deposition Exhibit 22,
13 2016 Ohio Drug Overdose Data Summary
14 From the Ohio Department of Health,
15 Beginning with Bates Label SUMMIT
16 820711, was for purposes of
17 identification.)

18 - - - - -

19 Q. We are at Exhibit 22, which is now
20 in front of you. This is a 2016 Ohio Drug
21 Overdose Data Summary From the Ohio Department
22 of Health. So this is the same version of the
23 document we were looking at for 2015, but now
24 it is for 2016; do you see that?

25 A. Yes.

1 Q. And it says that in 2016, if you
2 look towards the bottom of that first
3 paragraph, there were the fewest unintentional
4 overdose deaths involving prescription opioids
5 since 2009, when you exclude deaths involving
6 fentanyl and related drugs; do you see that?

7 A. Yes.

8 Q. Why do you think that is the case;
9 what accounts for that?

10 A. We were getting rid of the pills.
11 You know, we dropped off the ability for
12 individuals to get the pills. We dropped off
13 the ability for new people to get the pills and
14 start their addiction. We were giving out the
15 Detera bags, which is the activated charcoal
16 bags, to have people clear out their medicine
17 cabinets, we were promoting the dump boxes in
18 all the police precincts, to please bring in
19 all your pills and your grandparents' pills and
20 dump them, so that nobody can grab them out of
21 your medicine cabinet, whether it's the plumber
22 or the neighbor next door.

23 So we really -- we greatly
24 decreased the -- what had been a smorgasbord of
25 pills available everywhere in the state, to a

1 much smaller amount, cut off the added flow
2 between doctor shopping and things with OARRS,
3 and the problem is, we still have these people
4 who are addicted to opiates, and many of whom
5 had started with the original pills out there,
6 and they are going to find, because that's the
7 definition of addiction, they are going to find
8 an alternative, and they go to the street more
9 and more.

10 Q. Do you know who has been sued in
11 this lawsuit?

12 A. Generally, yes, not specifically.

13 Q. What is your understanding about
14 that?

15 A. I believe it's pharmaceutical
16 companies that manufactured any of the opiates
17 and pharmacy companies that distributed them.

18 Q. When you say, "Pharmacy companies
19 that distributed them," what do you mean by
20 that? You mean the pharmacies --

21 A. The pharmacies, yeah.

22 Q. -- where people go and have the
23 drug dispensed?

24 A. Yes. So CVS, Walmart here at the
25 table, and so forth, yes.

1 Q. Are you familiar with the concept
2 of a wholesale drug distributor in the delivery
3 of healthcare in the United States?

4 A. Only lightly.

5 Q. Do you know whether any wholesale
6 distributors have been sued, as part of this
7 lawsuit?

8 A. I don't recall. When I glanced at
9 the complaint, and again really truly glanced,
10 it was a lengthy list of individuals on the
11 defense side. So I would probably assume, yes,
12 but I didn't read it that carefully.

13 Q. Well, there is a long list, right?
14 But let me ask you a maybe more relevant
15 question.

16 Are you, as the Summit County ADM
17 Board chief clinical officer and medical
18 director, aware of any particular conduct by
19 closed-system wholesale distributors that you
20 believe has materially contributed to the
21 opioid epidemic in Summit County?

22 MR. KEARSE: Object to form.

23 A. Not knowing enough about the whole
24 process, I haven't formed an opinion about that
25 either way.

1 Q. Let's just take a break now, if we
2 could.

3 THE VIDEOGRAPHER: Off the record.
4 4:51.

5 (Recess taken.)

6 THE VIDEOGRAPHER: We are back on
7 the record, 5:13.

8 EXAMINATION OF DOUGLAS A. SMITH, M.D., DFAPA
9 BY MR. CARTER:

10 Q. Good afternoon, doctor.

11 A. Good afternoon.

12 Q. I introduced myself on the record,
13 but we haven't had a chance to meet. My name
14 is Ed Carter, and I'll be asking you some
15 questions, okay?

16 A. Okay.

17 Q. Because you guys have covered so
18 much, I'm going to jump around a little bit.
19 The same rules apply, in terms of if you don't
20 understand one of my questions or if you need
21 clarification, will you let me know?

22 A. I will.

23 Q. And as I jump around, if you lose
24 track of where I am, will you let me know, so I
25 can reorient you?

1 A. Yes.

2 Q. Okay. What is the Diagnostic and
3 Statistical Manual?

4 A. So the DSM is the book that we use
5 in psychiatry that -- and mental health, that
6 lists the diagnoses that are mostly based on
7 research, and it gives us a basic collection of
8 things that we can use to communicate amongst
9 clinicians effectively, without having to
10 detail all the symptoms.

11 We they can say somebody has X, say
12 a major depressive episode, and that
13 automatically tells that clinician a lot of
14 information about the illness. So it's our way
15 of giving a diagnosis, just like in medicine,
16 they have other manuals.

17 Q. And that manual is published by the
18 APA, correct?

19 A. That's correct.

20 Q. The American Psychiatric
21 Association?

22 A. Correct.

23 Q. And the current edition is the
24 DSM-5, right?

25 A. That's correct. Since 2013, yes.

1 Q. And under the DSM-5, there is an
2 entire section that refers to substance-use
3 disorders, correct?

4 A. Correct.

5 Q. And opioid-use disorder is one of
6 the different types of substance-use disorders
7 outlined in the DSM-5, correct?

8 A. Yes.

9 Q. Does the DSM-5 use the term
10 "addiction" as a diagnosis?

11 A. I don't believe it does, no.

12 Q. It refers to a use disorder,
13 correct?

14 A. That's correct.

15 Q. And clinicians, such as yourself,
16 according to the DSM, sometimes use the term
17 addiction to refer to the more severe
18 presentations of a use disorder, correct?

19 A. Yes.

20 Q. So if we go to the criteria for an
21 opioid use disorder, there will be the
22 discussion of what you are looking for is a
23 pattern of use that reflects or results in
24 clinically significant impairment or distress,
25 and it is evidenced by two or more of the

1 various criteria that are outlined in the DSM,
2 correct?

3 A. That's correct.

4 Q. And there is a scale, so that if
5 someone has two or three -- I think it is
6 actually two, four, it's mild, five or six is
7 moderate, and then more than six is severe,
8 correct?

9 A. That sounds correct, yes.

10 Q. And in the course of those 11
11 criteria that are outlined for an opioid-use
12 disorder, clinicians, such as yourself,
13 understand you don't use that as a checklist,
14 correct?

15 A. What do you mean?

16 Q. You can't -- a layperson can't just
17 go through that and apply it as a checklist.
18 It's something intended to be used with medical
19 and clinical judgment, correct?

20 A. That's correct.

21 Q. And that training enables you to
22 apply DSM to a patient that you see in a
23 clinical setting, correct?

24 A. Yes.

25 Q. Okay. Have you ever used DSM to

1 diagnose a patient with an opioid-use disorder
2 in a clinical setting?

3 A. I am certainly capable of it, and
4 I'm sure it happened on occasion in the state
5 hospital. I have not done that in my job at
6 ADM, since I'm not -- other than challenging
7 cases, I'm not seeing them directly.

8 Q. And sitting here today, do you have
9 a specific recollection of a case in the
10 clinical setting where you did that?

11 A. No.

12 Q. Have you ever applied DSM-5's
13 opioid-use disorder criteria in a forensic
14 setting, since being part of the ADM Board?

15 A. No, I have not.

16 Q. So is it fair to say, in your
17 medical practice, you have never diagnosed a
18 resident of Summit County with an opioid-use
19 disorder?

20 A. Correct.

21 Q. And likewise, even though it is
22 understood as a severe form of the disorder,
23 you have never diagnosed a resident of Summit
24 County with an addiction to opioids, correct?

25 A. Correct.

1 Q. And that's either in a clinical or
2 forensic setting, true?

3 A. True.

4 Q. Based on your training and
5 experience, would you agree that you could not,
6 as a medical matter, diagnose a patient with an
7 opioid-use disorder simply by knowing that they
8 use the substance; you would need more
9 information to make that diagnosis, correct?

10 A. Correct.

11 Q. So you couldn't just say, you know,
12 person X uses hydrocodone, therefore, they have
13 a use disorder. You would need that full
14 clinical picture to be able to run through DSM,
15 applying your medical and clinical judgment,
16 correct?

17 MR. KEARSE: Object to form.

18 A. Yes. I'd want to make sure they
19 meet official criteria.

20 Q. And you explained earlier that you
21 don't personally prescribe opioid medications,
22 but you do prescribe medications such as
23 antidepressants, SSRIs, things of that nature,
24 correct?

25 A. Yes.

1 Q. And those medications have
2 potential for abuse, correct?

3 A. Not much with antidepressants, no.

4 Q. What about withdrawal, if someone
5 doesn't go off those following the physicians'
6 orders, if someone abruptly stops the use of an
7 SSRI, can there be a withdrawal syndrome?

8 A. Yes. There is -- well, I'm not
9 sure if they officially call it withdrawal, but
10 there is definitely an effect when the brain
11 suddenly doesn't have what it was getting from
12 a medication, and people do have symptoms of
13 abrupt stopping of medications, like Zoloft,
14 for example.

15 Q. And one of the potential
16 consequences of someone abruptly stopping one
17 of those medications is there is an increased
18 risk of suicide, correct?

19 A. Potentially, yes.

20 Q. But despite the risks associated
21 with the misuse or someone not following
22 doctor's orders with those types of substances,
23 there is still appropriate medical use for
24 those substances, correct?

25 A. Yes.

1 Q. Now, in terms of individual
2 clinical cases in Summit County, do you know
3 the details of any conversation a patient who
4 is prescribed prescription opioids in Summit
5 County had with their prescribing physician,
6 regarding the risks or the proper use of that
7 substance, do you have any information about
8 what that doctor-patient interaction was, in
9 any specific individual?

10 MR. KEARSE: Object to form.

11 A. No.

12 Q. Do you know what any treating
13 physician told any member of Summit County, in
14 terms of the warnings that they gave, regarding
15 the properties of their prescription?

16 A. No.

17 Q. Do you have any information
18 regarding what any pharmacist may have told the
19 patients at the dispensing level about the
20 risks of using those prescription opioids?

21 A. No.

22 Q. In the course of your clinical
23 practice, have you ever made a medical
24 decision, based on something an opioid
25 manufacturer, distributor, or pharmacy ever

1 said publicly about prescription opioids?

2 MR. KEARSE: Objection.

3 A. As I said, I don't -- haven't -- I
4 don't prescribe opiates, so, no.

5 Q. Have you ever made any public
6 policy decisions, in your role on the ADM
7 Board, that you based on a statement from one
8 of the defendants in this case?

9 A. I don't set public policy, so, no.

10 Q. Have you ever set ADM Board
11 initiatives or figured out how to best use
12 funds, based on something one of the defendants
13 in this case said about prescription opioids?

14 A. No.

15 Q. In terms of people that do use
16 prescription opioids, fair to say there are a
17 number of people who use prescription opioids
18 and never go on to use heroin?

19 A. Yes.

20 Q. Fair to say there are a number of
21 people who use prescription opioids and never
22 go on to break the law, in trying to obtain
23 opioids?

24 A. Yes.

25 Q. And that includes people that would

1 be described as addicted to opioids? There are
2 people addicted to opioids that never go on to
3 use heroin, correct?

4 A. Correct, if they find some other
5 source for the opiates. The definition of
6 addiction, if they can't obtain those
7 substances, they are very highly likely to move
8 on to finding them on the street or moving on
9 to heroin.

10 Q. And just to be clear, since we have
11 talked about addiction an awful lot today,
12 based on your medical training, the definition
13 that you would use of addiction is what the APA
14 sets forth in terms of a severe form of an
15 opioid-use disorder, or one of the other
16 substance-use disorders as defined in DSM-5; is
17 that correct?

18 MR. KEARSE: Object to form.

19 Q. Let me ask you, how would you
20 define addiction? How did you in your practice
21 understand addiction?

22 A. So addiction, agreed, that we would
23 use the DSM-5 to give the official diagnosis,
24 as well as mild, moderate, severe, but
25 addiction itself is, again, I've said before,

1 it's the individual who is either using the
2 substance, thinking about using the substance,
3 or actually obtaining the substance, and that's
4 basically what they do, that's how they spend
5 their time, and they do it despite continuing
6 to use and all that, despite the negative
7 consequences that it is causing to them, their
8 family, their finances, their job, et cetera.

9 Q. And it is true, is it not, that all
10 of those clarifications you just added are just
11 actually within the substance-use disorder
12 category of DSM, correct?

13 A. Correct.

14 Q. And one of them, for example, is a
15 significant amount of time using or trying to
16 obtain the substance, that's one of the first
17 criteria, correct?

18 A. That's correct.

19 Q. Problematic, you know, people
20 making sacrifices in their social lives or in
21 their work lives or disruption, those are all
22 individual criteria under the substance-use
23 disorder framework, correct?

24 A. Correct.

25 Q. Cravings, you mentioned thinking

1 about it, cravings for a substance, that's a
2 criteria under DSM as well, correct?

3 A. Correct.

4 Q. And used despite known harms,
5 that's another DSM criteria, correct?

6 A. Correct.

7 Q. So at the broadest level, there are
8 different aspects of it that you've described,
9 but it all is articulated in that DSM
10 framework, fair?

11 A. Yes. It is pretty thorough, yeah.

12 Q. Now, with addictions generally, you
13 agree that all addictions can be overcome,
14 correct?

15 MS. KEARSE: Object to form.

16 A. What do you mean by "overcome"?

17 Q. Well, people treat addiction,
18 right?

19 A. Yes.

20 Q. And when a patient comes in for
21 alcohol addiction, cocaine addiction, or
22 prescription opioid addiction, no patient is
23 ever told, "You might as well give up, there is
24 no hope, it's an addiction, you can never beat
25 it, you know, that's going to be the rest of

1 your life," that is something medical
2 professionals never tell someone who comes in
3 for addiction treatment, correct?

4 MR. KEARSE: Object to form.

5 A. So we would not tell them there is
6 no hope, but we would, in fact, tell them that
7 it is a chronic illness and that they are going
8 to need treatment, perhaps, the rest of their
9 lives, as opposed to strep throat, where you
10 are going to take ten days of antibiotics and
11 it's gone. So there is hope, but it is not a
12 onetime and you are done type of an illness.

13 Q. Right. You would give them
14 accurate information about the challenges, but
15 you would never say this is a condition that
16 you are not going to be able to deal with or
17 live with or overcome the consequences of, you
18 would never give that message, right?

19 MR. KEARSE: Object to form.

20 A. Correct. We would always maintain
21 hope.

22 Q. And that's one of the things that
23 the various task forces and organizations that
24 you have been involved in, one of the options
25 treatment of addiction, correct?

1 A. Certainly.

2 Q. And the use of a substance
3 resulting in addiction, all substance users,
4 even addicted substance users, still maintain
5 the ability to make the decision to try and
6 quit, correct?

7 MS. KEARSE: Object to form.

8 A. No, that's not accurate.

9 Q. What circumstances would addiction
10 deprive a person of the ability to try and
11 quit?

12 A. Many circumstances, actually. So
13 the illness, once it has tricked your frontal
14 lobes into believing that you must have the
15 substance to survive, that is literally how
16 your brain interprets it, that you must have
17 it, you need the opiate more than you need
18 water, more than you need food, more than you
19 need sex to survive, it is -- it becomes,
20 number one, as your drive, it is a true drive
21 at that point.

22 Many people go pretty deep into
23 despair, destruction of their lives and all
24 aspects before, often times, somebody, like law
25 enforcement or a judge, says, "You are going to

1 get help."

2 So it's not like it's a choice, not
3 that they can just choose to get help. It is
4 true that if given the right circumstances,
5 which may be coercive circumstances, you know,
6 prison for ten years versus we are going to
7 give you a drug court treatment, coercive, then
8 the person can get help, but I wouldn't
9 characterize it as every person can choose to
10 get well.

11 Q. With the proper internal motivation
12 and external support, every addicted person can
13 get treatment, correct?

14 MS. KEARSE: Object to form.

15 A. Yes. If they can get to that stage
16 of change, which I will use as your internal
17 motivation, yes.

18 Q. And even addicted individuals still
19 have to go through the physical and mechanical
20 act of obtaining the substance and, you know,
21 injecting it or putting the pill in their
22 mouth, correct, or smoking a cigarette or
23 drinking a shot of whiskey?

24 MS. KEARSE: Object to form.

25 A. Even, you said even the --

1 Q. Yeah. Even individuals that are
2 addicted, that is there is still a mechanical
3 behavioral aspect, they have to take the
4 substance, correct?

5 A. Even implies compared to who?

6 Q. Get rid of the word even. All
7 users of a substance are -- to use that
8 substance, they have to mechanically take it,
9 ingest it, in whatever form they are using it,
10 correct?

11 A. Yes.

12 Q. And addicted individuals do not
13 become mindless zombies who are compelled,
14 against their free will, to take a substance,
15 correct?

16 MR. KEARSE: Object to form.

17 A. I disagree with that.

18 Q. So the brain changes that you
19 talked about, it is true that changes to the
20 brain receptors, when the substance is gone
21 from the system, those changes to the brain
22 revert back to normal levels, correct?

23 A. So when somebody is taking a
24 substance, their brain does change, becomes
25 less -- make it simple, less sensitive to the

1 substance. So they need more and more of the
2 substance to get the same effect, and to
3 maintain the feeling they are trying to get.

4 Again it is driven by the
5 addiction, not by thinking, and to avoid
6 withdrawal, which is the second reason that
7 they maintain the addiction, so they
8 would -- they would have two drivers that would
9 keep them going.

10 There is no -- so they really are
11 being compelled by their illness to obtain,
12 mix, inject, snort the substance. It is not
13 a -- not really a conscious thought process, in
14 the sense of making a decision about whether to
15 eat pizza or a sandwich today. It is much more
16 driven by this animal need, this true drive
17 that you must have this substance.

18 Q. And the animal need you are talking
19 about, it is the pleasure response system of
20 the brain, correct?

21 A. Correct.

22 Q. And in terms of the brain
23 chemistry, there are receptors within the brain
24 that various substances bind to and then they
25 release substances -- for example, dopamine is

1 released, and that's part of the conditioning
2 that is -- response, as you said, in some
3 individuals can lead on an addiction, correct?

4 A. Correct.

5 Q. And in terms of that brain
6 chemistry, the way that the receptors interact
7 with the substance, if you looked at -- you
8 know, you have seen, in the course of your
9 medical research, that people can take PET
10 scans of deceased individuals to scan the
11 brain, correct?

12 A. Yes.

13 Q. And psychiatry does that, you have
14 seen studies like that, where they look at the
15 receptor activation in, for example, a deceased
16 smoker's brain, to see the dopamine release;
17 have you seen things like that?

18 A. Yes.

19 Q. Okay. And so if you look at the
20 brain chemistry of someone who has never taken
21 a prescription opioid, and then you look at
22 someone who has been abstinent from a
23 prescription opioid for six months, those brain
24 scans, in terms of the receptor structure and
25 the presence of those chemicals, would look

1 identical, correct?

2 A. So given our current technology,
3 they would look identical, but the person who
4 is in recovery for six months is at much
5 greater risk of relapse, at least over that
6 ensuing year, at least 18 months total,
7 compared to that always-normal brain that never
8 had the addiction.

9 Q. And so withdrawal from a person who
10 is coming off of opioids, that usually lasts
11 seven to ten days, correct?

12 A. Yes. Sometimes less, yes.

13 Q. And the peak, in the ordinary case,
14 is three to four days, correct?

15 A. Yes.

16 Q. And do you know what the half-light
17 is -- excuse me -- the half-life is of the
18 chemicals in opioids; how long after someone's
19 last dose does it take to be out of their
20 system?

21 A. They all vary. So fentanyl would
22 be much longer than Percocet, for example.

23 Q. Do you know the half-life for
24 oxycodone?

25 A. I don't think it's very long,

1 actually. Eight or 12 hours, I think.

2 Q. So within eight or 12 -- assuming
3 that that's correct, within eight or 12 hours
4 after taking the last dose of oxycodone, that
5 chemical would be out of the user's system,
6 correct?

7 MS. KEARSE: Object to form.

8 A. Well, half of it would be out of
9 the user's system, then half again the next.
10 That's the definition of half-life.

11 Q. The half-life is 8 to 12 hours?

12 A. Yes.

13 Q. Okay. I misunderstood.

14 Do you know what the half-life is
15 for hydrocodone?

16 A. I don't. It is probably similar.

17 Q. In the course of your career, have
18 you seen anyone in Summit County who has died,
19 had their death identified as being caused by
20 prescription opioids, and a case where that
21 person was using those prescription opioids, as
22 directed by a physician; have you ever seen a
23 case like that?

24 MR. KEARSE: Object to form.

25 A. I've not been -- I should say, I

1 don't see the case, so I have not been informed
2 by the medical examiner's office that they have
3 had a case where somebody died on taking
4 exactly the prescribed doses of a prescription
5 opiate, no.

6 Q. In the course of your work, have
7 you become aware of any specific resident of
8 Summit County who died as a result of
9 prescription opioid pills distributed,
10 manufactured, or dispensed by any of the
11 defendants in this case?

12 MR. KEARSE: Object to form.

13 A. I don't know that anybody has ever
14 looked to see where -- you know, which pharmacy
15 or which company they got it from.

16 Certainly Dr. Kohler's office looks
17 to see, tries to figure out whether it was
18 prescription pills versus illicit substance
19 from the street and, to the extent that they
20 are prescription opiates, I'm sure they came
21 from some defendant or defendants in the case.

22 Q. Now, putting other people aside,
23 you personally, have you made the
24 determinations, are you aware of any specific
25 individual in Summit County whose death was the

1 result of prescription opiate pills linked to
2 one of the defendants; is that something you
3 know?

4 A. I wouldn't know the link.

5 Q. Are you aware of any instance where
6 prescription medications were diverted from a
7 retail pharmacy in Summit County?

8 A. No.

9 Q. You mentioned, and it is reflected
10 in some of the documents that were marked as
11 exhibits, public perceptions about the safety
12 of prescription opioids; do you recall talking
13 about that generally?

14 A. Yes.

15 Q. Now, in terms of the information,
16 the comments describing those public
17 perceptions, are you an expert in the history
18 of public opinions regarding prescription
19 opioids?

20 A. You would have to define expert, I
21 guess.

22 Q. Do you hold yourself out as an
23 expert historian?

24 A. No, sir.

25 Q. Have you undertaken any systematic

1 study of public perceptions in Summit County of
2 the health effects or addictive nature of
3 prescription opioids?

4 MR. KEARSE: Object to form.

5 A. No.

6 Q. Do you consider yourself an expert
7 in risk perception?

8 A. No.

9 Q. Do you hold yourself out as an
10 expert in polling or the study of public
11 opinion on various issues?

12 A. At least one, yes.

13 Q. What is that issue?

14 A. Dr. Thrasher and I did a survey
15 of -- attempted a survey, not everybody -- many
16 didn't respond -- of every physician in Ohio
17 about what was encouraging them to prescribe
18 opiates, when they didn't want to, including
19 patient satisfaction surveys and all that.

20 So in that case, we did a pretty
21 thorough poll. Sadly, with everybody being
22 busy, we didn't get a response rate at a level
23 that we thought, basically, we should publish
24 it. So we didn't do that, but...

25 Q. So you mentioned that survey that

1 you and Dr. Thrasher put out. So you, for that
2 purposed, had a scientific methodology, and you
3 tried to get a fair sample, and you said you
4 designed the survey to try to get accurate
5 information that you thought would withstand
6 scientific methods, fair?

7 A. Yes.

8 Q. And in terms of that methodology,
9 have you applied that methodology in any other
10 area related to prescription opioids?

11 A. No.

12 Q. So you haven't done any other
13 survey on attitudes or beliefs related to
14 prescription opioids, correct?

15 A. Correct.

16 Q. Including what the public
17 perception was, whether they were safe,
18 dangerous or somewhere in between?

19 A. Correct.

20 MR. KEARSE: Object to form.

21 Q. The survey that you and Dr.
22 Thrasher performed, did you submit it for peer
23 review?

24 A. No. As I said, we didn't get
25 enough response rate to give the results to

1 anybody.

2 Q. Okay. So when you saw the response
3 rate, you realized that that was the
4 information you collected, but in terms of
5 formalizing it, that was the end of the road,
6 for that particular survey?

7 A. Correct. There weren't enough
8 responses to make it rigorous enough, as far as
9 research.

10 Q. Was one of the questions that you
11 asked in that survey whether pharmaceutical
12 marketing played a role in the physician's
13 prescribing behavior?

14 A. I honestly don't recall.

15 Q. Okay. We will get copies and come
16 back to that.

17 You mentioned a presentation that
18 you were asked to give in 2016 to the ADM
19 Board, after carfentanil had come on the scene
20 the Fourth of July weekend; do you recall that?

21 A. Yes.

22 Q. I would like to mark -- well, I
23 have marked, and I'll hand down to you Exhibit
24 23.

25 - - - - -

1 (Thereupon, Deposition Exhibit 23,
2 Presentation Given by Dr. Smith, was
3 marked for purposes of
4 identification.)

5 - - - -

6 Q. Take a moment to familiarize
7 yourself with Exhibit 23.

8 A. Sure.

9 Q. Do you recognize this as a
10 presentation that you have given?

11 A. Yes, multiple times.

12 Q. And there are some notes, towards
13 the back. This has page numbers in the
14 presentation, because it was in native format,
15 and although the page numbers are somewhat
16 sporadic, it would be page 17, there is some
17 notes for slide 63; do you see that?

18 A. I do.

19 Q. And then you see some individual's
20 names. Who is Mary Sonnhalter?

21 A. So this may be my presentation. I
22 didn't add any notes.

23 So Mary Alice Sonnhalter was our
24 marketing and promotions person, worked with
25 newspapers and things like that. It is now

1 Chrissy Gahash. She retired the end of last
2 year, I guess.

3 Q. Who is Eric -- I'm sorry.

4 A. Go ahead.

5 Q. Who is Eric Hutzell?

6 A. Eric, as I mentioned earlier, is
7 our data analyst/research person, who really
8 looks at the data and gives us the -- gives us
9 these ending charts and graphs and so forth.

10 Q. And while the presentation itself
11 is not dated, the comments embedded in the
12 presentation that we just are looking at are
13 indicated September 8, 2016; do you see that
14 date?

15 A. I do see that, yes.

16 Q. Is that around the time that it was
17 your best estimate of when you gave the
18 presentation to the ADM Board that they
19 requested after carfentanil hit in July?

20 A. Yes. I'm thinking it would have
21 been September 20 something of 16, yes.

22 Q. If you turn to page 7 -- well, let
23 me ask you a broader question, and it may take
24 you a minute to flip through.

25 Do you know if this presentation

1 mentions the word "carfentanil" anywhere in it?

2 A. Well, I can look.

3 Q. Okay. Please do.

4 A. I should say, however, although the
5 notes are old, the slides I keep updating with
6 new data. So they may not -- they might have
7 said it in September of 16, and they might not
8 say it now, but I'll look.

9 Okay. So I don't see carfentanil
10 but -- hang on. I don't see carfentanil, but
11 it actually looks like the printed date is
12 November of 18, but this was actually from
13 September of 16.

14 Q. And I'll represent to you the
15 printed date is when I printed it off from the
16 production.

17 A. Okay.

18 Q. So in any event, at the time -- at
19 this time, September of 2016, had Summit County
20 been able to publish data of what had just
21 happened a couple months earlier, with respect
22 to the arrival of carfentanil in the county?

23 A. We wouldn't have yet, because we
24 were doing the data quarterly, and so that
25 would have fallen in a quarter later, before

1 Eric would have been able to add that to our
2 charts and graphs.

3 Q. When you gave that presentation
4 that the board requested in September of 2016,
5 do you recall whether you made any updates to
6 what was your standard deck, specifically to
7 address carfentanil?

8 A. I don't believe that I would have
9 changed a chart or a graph for that. I would
10 have talked about it, other than I have
11 a -- let me see if it's in here.

12 So I did add -- it's not in this
13 presentation. I did add a graphic that
14 shows -- looks like a graphic of a pill and
15 shows the relative strength of morphine, the
16 base chemical that our brain deals with, that
17 are brain actually deals with opiate-wise, and
18 then heroin, fentanyl, carfentanil, showing
19 that carfentanil is much more potent, but that
20 graphic was added after that.

21 Q. I would like to ask you about one
22 slide in this presentation. If you turn to
23 numbered page 7, on the bottom left, there is a
24 chart with a brain and a bunch of words,
25 correct?

1 A. Yes.

2 Q. The title of this slide is Pleasure
3 Centers, correct?

4 A. Yes.

5 Q. And this is something designed to
6 illustrate the point that the brain -- the
7 brain function that we described earlier, in
8 terms of various things that trigger positive
9 reinforcement in the brain's pleasure reward
10 system, correct?

11 A. Correct. I use it to demonstrate
12 that we all have certain things, that everyone
13 is a little different, so that whereas some
14 person may be turned on by Liam Neeson,
15 somebody else might be turned on by Chicago
16 pizza.

17 So I use that to -- and generally
18 to get a little bit of humor from a sad topic,
19 I'll usually tell people that I'm pretty
20 certain all of us would agree on sex with
21 chocolate would be a good one, and that usually
22 gets a laugh.

23 Q. And what about the failures of
24 others, why is that so prominently displayed on
25 there?

1 A. Oh, I -- you can ask Stivers, who
2 created that.

3 Q. Okay.

4 A. Some people are, I guess, more
5 sadistic than others.

6 Q. I would like to mark as Exhibit 24
7 the following.

8 - - - - -

9 (Thereupon, Deposition Exhibit 24,
10 Composite Exhibit, Beginning with
11 Bates Label SUMMIT 880095, was
12 marked for purposes of
13 identification.)

14 - - - - -

15 Q. Now, I'll tell you, this is a
16 longer exhibit than I intend to use, but I want
17 to just orient us to it, nonetheless.

18 This is a composite exhibit that
19 starts with Summit 000880095, and continues
20 sequentially through ending Bates 145. It
21 starts with a cover sheet that has the minutes
22 from the January 21, 2014 meeting of the ADM
23 Board, correct?

24 A. Yes.

25 Q. All right. And the part that I

1 wanted to ask you about is very close to the
2 end. It starts on ending Bates 140; do you see
3 that?

4 A. Yes.

5 Q. Now, the top of the page ending in
6 140 says Summit County ABM Board Fiscal Year
7 2014 Community, Plan Attachment 2; do you see
8 that?

9 A. Yes.

10 Q. And what does this depict?

11 A. So part of our approach was to help
12 instill hope, show that people can, in fact,
13 get back into -- either back or for the first
14 time into recovery, and these are individuals
15 telling their stories of hope, including --
16 yeah, and these are people who are willing to
17 put their faces out there on the -- because
18 they are on our website, so, publically.

19 Q. So these are actual testimonials,
20 correct?

21 A. That's correct.

22 Q. And none of these are, you know,
23 manufactured or made up. These are real people
24 telling real stories, correct?

25 A. Correct.

1 Q. And below the featured story
2 section, there is a little bit of text that
3 says, "Alcoholism, drug addiction, mental
4 illness are real medical conditions that can
5 affect anyone. People can live rich and
6 fulfilling lives with the right services and
7 supports funded by the ADM Board"; did I read
8 that correctly?

9 A. That's correct.

10 Q. And the stories of hope that the
11 ADM Board is offering are hope to people that
12 are struggling with addiction, correct?

13 A. Yes.

14 Q. And so the first individual, Jarod,
15 the headline next to his video says, "Today, I
16 am in control of my future," correct?

17 A. Yes.

18 Q. So this is someone who was dealing
19 with addiction, but as a result of the
20 treatment that was provided, is able to feel
21 like he's in control of his future, correct?

22 A. Right. You can see it says, in
23 micro print, "After multiple attempts in
24 detox," et cetera. So it also is very
25 real-world, because it demonstrates it is a

1 challenging illness to gain full control over
2 and may require repeated attempts to get that
3 treatment.

4 Q. And so motivation and persistence
5 are important in an individual addressing their
6 substance addictions, correct?

7 A. Yes, even though many times that
8 motivation is external.

9 Q. And persistence is necessary?

10 A. Yes.

11 Q. No matter how hard you, as a
12 physician, want someone to quit, at the end of
13 the day, you, as a physician, can't make that
14 decision for them, can you?

15 A. No.

16 MR. KEARSE: Objection. Form.

17 A. Correct, the patient plays,
18 certainly, a role in their own recovery.

19 Q. And they have to make a decision
20 for themselves that you can't make for them, as
21 a physician?

22 A. Correct.

23 MR. CARTER: Okay. Those are all
24 the questions I have. Thank you for your time.
25 I'll pass you over to co-counsel.

1 THE VIDEOGRAPHER: Off the record,
2 5:52.

3 (Pause.)

4 THE VIDEOGRAPHER: We are back on
5 the record, 6:01.

6 EXAMINATION OF DOUGLAS A. SMITH, M.D., DFAPA
7 BY MS. WEST FEINSTEIN:

8 Q. Good evening, doctor. We met
9 briefly before the beginning of today's
10 deposition, way back this morning, but I'll
11 reintroduce myself. My name is Wendy West
12 Feinstein, I'm with the law firm of Morgan
13 Lewis, and I represent the Teva defendants in
14 this litigation.

15 Were you aware that any claims were
16 brought against the Teva defendants in this
17 litigation?

18 A. Again, not specifically. They are
19 probably in the big list I glanced at.

20 Q. Are you familiar with any of the
21 prescription opioids that are manufactured by
22 any of the Teva defendants?

23 A. Probably good, in terms of
24 influence by pharmaceutical reps, but I never
25 seem to remember which company makes which

1 medication, so, no, I'm not sure which one Teva
2 makes.

3 Q. And you just mentioned
4 pharmaceutical reps. Have you been visited by
5 any detail representative from any Teva-related
6 entity?

7 A. Not that I'm aware of, no.

8 Q. And you have not been detailed by
9 any pharmaceutical representative regarding
10 opioid, prescription opioid medications, right?

11 A. Correct.

12 Q. And you have never, since being in
13 practice, since leaving the hospital, you do
14 not recall prescribing any opioid medications,
15 right?

16 A. Correct.

17 Q. We talked a little bit earlier
18 about the FDA approval process for opioids; do
19 you recall that testimony --

20 A. Yes.

21 Q. -- with one my colleagues?

22 And you mentioned that the FDA
23 process is rigorous and thorough, right?

24 A. Yes.

25 Q. Are you aware that, as a part of

1 the FDA approval process, that the FDA also
2 approves a package insert or labelling for a
3 product?

4 A. Yes.

5 Q. Have you read the FDA-approved
6 labels for any of the prescription opioids?

7 A. I think I did actually read a
8 couple way back in 13 or 14, as I was gathering
9 all the information, but it's been a while.

10 Q. Do you recall seeing a black box
11 warning on any of those labels that you
12 reviewed?

13 A. Sitting here today, I don't recall,
14 because I don't prescribe them, so...

15 Q. And do you know what I'm talking
16 about when I refer to a black box warnings?

17 A. Oh, yes.

18 Q. And can you describe for us what
19 your understanding is of a black box warning?

20 A. Sure. It indicates that there is a
21 potential for a serious, adverse event from
22 that medication in -- for example, in
23 antidepressants with younger individuals, there
24 is a black box warning against suicidality
25 increasing.

1 Q. You just mentioned that with
2 prescription opioids, you are not familiar with
3 the black box warning on their labels; is that
4 right?

5 A. Yeah. I don't recall what it was.

6 Q. Do you remember ever being informed
7 that prescription opioids include a black box
8 warning about addiction?

9 MS. KEARSE: Object to form.

10 A. No, but I wouldn't be surprised,
11 especially in the current environment.

12 Q. Do you know the last time, the most
13 recent time that any prescription opioid label
14 has been updated?

15 A. No.

16 Q. As part of the FDA's functions with
17 prescription medications in the U.S., are you
18 familiar with its involvement in reviewing
19 advertising for prescription drugs?

20 A. I'm familiar that maybe a decade
21 ago, at some point, there was a change, and
22 they added the warnings at the end of the
23 pharmaceutical commercials to give you the
24 adverse effects, potentials, as well as -- on
25 top of the positives that were being promoted

1 in the advertising.

2 I'm not sure exactly what year that
3 was, but in my mind's eye, it was about a
4 decade ago.

5 Q. You're not an expert in regulatory
6 affairs, are you?

7 A. No.

8 Q. You are not an expert in
9 pharmaceutical marketing, are you?

10 A. No.

11 Q. But you are aware that it is
12 permissible and lawful for pharmaceutical
13 manufacturers to advertise their medications,
14 right?

15 A. Yes.

16 Q. And that promotion is -- are you
17 aware that that promotion is reviewed and
18 evaluated by FDA at times?

19 A. Yes.

20 Q. Have you personally seen any
21 direct-to-consumer marketing related to
22 prescription opioids?

23 A. I have to think about that. I
24 don't watch much TV, so that wouldn't be where
25 it would get me. I have to think about medical

1 journals and stuff. I don't -- not in any
2 recent time, no.

3 Q. Have you seen any form of marketing
4 for prescription opioids?

5 A. Not in recent years.

6 Q. At any time?

7 A. I couldn't tell you what I saw a
8 decade ago, but...

9 Q. Nothing stands out to you --

10 A. Correct.

11 Q. -- as you sit here today?

12 A. No.

13 Q. Since you took the position at the
14 ADM Board and formed the Opiate Task Force, did
15 you review any prescription opioid marketing
16 materials?

17 A. No. I haven't looked into that, as
18 a part of my research, no.

19 Q. Are you aware of any
20 misrepresentation made by any manufacturer
21 relating to its prescription opioids?

22 A. Only by -- you know, others have
23 said that they've -- the Dr. Jick article and
24 things that were stated along the way, but not
25 directly to me.

1 Q. And Dr. Jick isn't a prescription
2 opioid manufacturer, is he?

3 A. No.

4 Q. Right. So are you aware of any
5 statements or misrepresentations made directly
6 by any manufacturer of prescription opioids?

7 A. No.

8 Q. Are you aware of any omissions
9 regarding risks, for example, made by any
10 manufacturer of prescription opioids?

11 A. No.

12 Q. Are you aware of any physician
13 within Summit County who has been misled by any
14 statements made by any manufacturer of
15 prescription opioids?

16 A. No. No one has come forward to
17 tell me that, so...

18 Q. Are you aware of any prescription
19 that has been written to any patient in Summit
20 County, on the basis of a misrepresentation
21 made by any pharmaceutical manufacturer?

22 A. No.

23 Q. Have you seen any information
24 regarding any agreement among pharmaceutical
25 manufacturers related to opioid marketing?

1 A. No.

2 Q. Have you seen any information that
3 ties any pharmaceutical manufacturer who
4 manufacturers prescription opioids to Dr. Jick?

5 A. Can you repeat that, please.

6 Q. Have you seen any information that
7 ties any pharmaceutical manufacturer of a
8 prescription opioid to Dr. Jick?

9 A. I think I've seen reference to that
10 in an article somewhere, as well as in
11 Dreamland. That's where I would have seen
12 that.

13 Q. But you personally aren't aware of
14 any data or evidence, other than what you read
15 in Dreamland; is that right?

16 MS. KEARSE: Object to form.

17 A. And there was some other article I
18 saw written, maybe it was because of Dreamland,
19 but it was actually in one of the medical
20 journals, but no, not directly in Summit
21 County.

22 Q. You mentioned that in your
23 research, you didn't come across any marketing
24 information performed by any of the
25 pharmaceutical manufacturers.

1 Can you please tell me what
2 research did you do after joining the ADM Board
3 or at any time relating to prescription
4 opioids?

5 A. I'm sure most of it was talking to
6 the addiction specialists in Summit County,
7 Department of Health, the Department of Mental
8 Health, which then became the Department of
9 Mental Health and Addiction Services, went to
10 the annual meeting of the American Academy of
11 Addiction Psychiatrists, and then through the
12 Opiate Task Force, we have had, kind of, a
13 constant flow of information that comes in,
14 much of which I get to look at, so...

15 Q. So when you are using the term
16 "research," you are not talking, sort of,
17 scientific research and epidemiological
18 studies; is that right?

19 A. Correct. Right. I'm not running
20 research projects on opiates. I do see a lot
21 epidemiological data through Summit County
22 Public Health.

23 Q. Is it fair to say that most of the
24 information that you have regarding the opioid
25 crisis and the opioid epidemic is from other

1 sources; it's not information that you have
2 developed on your own?

3 MR. KEARSE: Object to form.

4 A. Correct. We're -- our mission is
5 not to create that information. It's to use
6 the information to determine where to use our
7 funds to treat people in the county.

8 MS. WEST FEINSTEIN: Thanks,
9 doctor. I have the nothing further.

10 MR. KEARSE: Are you coming back?
11 You passed the witness already.

12 EXAMINATION OF DOUGLAS A. SMITH, M.D., DFAPA
13 BY MR. BOEHM:

14 Q. Okay. Dr. Smith, I have just a
15 couple of questions in reference to a point
16 that you made about some kind of survey study
17 that you thought about doing; do you remember
18 that?

19 A. Yes.

20 Q. I think you said that, in response
21 to a question about whether you hold yourself
22 out as an expert in certain fields, you kind of
23 suggested that you might hold yourself out as
24 an expert in one particular area, having to do
25 with this survey thing that you did; did I hear

1 that right?

2 MR. KEARSE: Object to form.

3 A. No. I said I had experience with
4 doing one particular survey with Dr. Thrasher
5 of all the physicians in Ohio. The attempted
6 survey, I guess I should say, because we got a
7 very dismal response rate. So I couldn't use
8 the data to reach any conclusions.

9 Q. Okay. Just to be clear then, and
10 make sure we have this very clear on the
11 record, do you consider yourself an expert in
12 survey methodology?

13 A. No.

14 Q. Did you have an expert in survey
15 methodology who was working with you and Dr.
16 Thrasher in preparing the questions or in
17 analyzing the survey results?

18 MR. KEARSE: Object to form.

19 A. So in that case, Dr. Thrasher --
20 again, I'm not the expert on opiates -- he did
21 vet the questions and so forth through a number
22 of individuals, some of whom may have had that
23 expertise, but I'm not aware of who they were.

24 The data analysis, again, not done
25 by an expert, because we didn't get enough

1 results to make it worth actual analysis.

2 Q. I see. So the data you received
3 back never even got analyzed by an expert; is
4 that right?

5 A. That's correct.

6 MR. BOEHM: Are we at 25?

7 THE NOTARY: I think so.

8 - - - - -

9 (Thereupon, Deposition Exhibit 25,
10 December 2014 Email Exchange,
11 Beginning with Bates Label SUMMIT
12 93592, was marked for purposes of
13 identification.)

14 - - - - -

15 Q. I have marked this document as
16 Exhibit 25, and it is an email Exchange --

17 MS. KEARSE: Wait. Can I have one?

18 MR. BOEHM: Oh, I'm sorry.

19 Q. This is an email exchange that I
20 think relates to this idea for a survey that
21 you referenced earlier in your testimony; is
22 that correct?

23 A. Yes, it does.

24 Q. And there is an email that --
25 actually, you start this email chain, if you

1 turn to page 2, right?

2 A. Yes.

3 Q. You say, "Dr. Thrasher and I are
4 working with two physicians from NEOMED about a
5 plan to conduct a survey of all" -- and the
6 word all is in all caps, right?

7 A. Yes.

8 Q. " All Ohio physicians on factors
9 that contribute to physician prescribing
10 practices for opiates"; did I read that right?

11 A. Yes.

12 Q. Who were the two physicians that
13 you and Dr. Thrasher were working with from
14 NEOMED?

15 A. From NEOMED, it would have been Dr.
16 Mark Munetz, I'm sure, and 2014, I'm not sure
17 who the other doctor would have been. There
18 was only one -- the battery is low on your
19 phone.

20 MR. BOEHM: Make sure it is plugged
21 in.

22 A. From NEOMED, I don't know,
23 actually, at the moment who the other person
24 who have been, since there is only one I can
25 think of at NEOMED right now.

1 Q. Okay. And you attached to this
2 email, it looks like, maybe some drafts or
3 proposed questions that might be used for the
4 survey --

5 A. Yes.

6 Q. -- do you see that?

7 A. Yes.

8 Q. And you solicit feedback from the
9 recipients, right?

10 A. Correct.

11 Q. Are any of the individuals who are
12 recipients of this email experts in survey
13 methodology?

14 A. Survey methodology -- addiction,
15 yes, survey methodology, no.

16 Q. You do get some feedback from -- is
17 that Dr. Michelle Blanda?

18 A. Yes.

19 Q. And she raises the issue of the
20 standards from the JCAHO; is that the Joint
21 Commission?

22 A. Yes, it is.

23 Q. She says, "The standards for Joint
24 Commission is that patients have a right to
25 have their pain addressed"; do you see that?

1 A. Yes.

2 Q. And she says, "I would include some
3 definition of the standards that you are
4 referring to"; do you see that?

5 A. Yes.

6 Q. What did you understand Dr. Blanda
7 to mean?

8 A. I think she was concerned that not
9 all physicians would even be aware that Joint
10 Commission had standards. Not all physicians
11 work in a setting accredited by Joint
12 Commission. So she was asking that we
13 enumerate what the standard was, so that all
14 physicians, you know, could respond to it, as
15 opposed to only ones working in a setting,
16 although there are many of them that are
17 accredited by Joint Commission.

18 Q. What percentage, if you know, of
19 hospitals and private practices are accredited
20 by the Joint Commission, as opposed to those
21 that are not?

22 A. Sure. So a private practice, zero
23 percent.

24 Q. That's not -- a private practice
25 wouldn't be accredited by Joint Commission --

1 A. Correct.

2 Q. -- is that right?

3 A. That's correct.

4 Q. So the Joint Commission would --

5 A. Like a clinic --

6 Q. -- accredit hospitals?

7 A. Sorry. Yeah. Hospitals, clinics,
8 larger entities that -- an individual
9 physician, I don't think he or she could comply
10 with the book of Joint Commission standards,
11 because you need a bunch of people to be able
12 to fulfill a lot of the standards, so...

13 - - - - -

14 (Thereupon, Deposition Exhibit 26,
15 Surveying Ohio Physicians on Opiate
16 Prescribing Behaviors, Beginning
17 with Bates Label SUMMIT 839795, was
18 marked for purposes of
19 identification.)

20 - - - - -

21 Q. And you all put together a draft
22 article in connection with the results that you
23 received back from your survey, right?

24 This would be -- I just marked
25 Exhibit 26; is that right?

1 A. Yeah. Dr. Thrasher did actually
2 write that.

3 Q. Did you help draft this?

4 A. He wrote it, I'm sure I reviewed
5 it, but he actually wrote i.

6 Q. And the title is Surveying Ohio
7 Physicians on Opiate Prescribing Behaviors?

8 A. Yes.

9 Q. And it says, about a third of the
10 way into the first paragraph there, that, "A
11 survey was created and distributed to Ohio
12 physicians and podiatrists" and skipping just a
13 little bit further, it says, "The response rate
14 was 11.8 percent," right?

15 A. Yes.

16 Q. And your view was that response
17 rate is too low for there to be reliable
18 results, is that --

19 A. Yeah. It's hard to translate that
20 to all physicians' thoughts when there were
21 something like 47,000 physicians that it went
22 out to and about 900 podiatrists, because they
23 are part of the same board.

24 Q. The final sentence of the abstract
25 says, "Pharmaceutical marketing and continuing

1 medical education were more likely to decrease
2 a physician's opiate prescribing with more
3 years of experience"; did I read that right?

4 A. Yes. It means that physicians with
5 more years of experience, they are less likely
6 to be affected by pharmaceutical marketing.

7 Q. It actually says that it would
8 decrease a physician's opiate prescribing --

9 MR. KEARSE: Object to form.

10 Q. -- right? In other words, there
11 are two factors here: One variable is
12 pharmaceutical marketing and CMEs, and
13 continuing medical education --

14 A. Right.

15 Q. -- and information, training that
16 doctors receive, right?

17 A. Uh-huh.

18 Q. But that was associated with a
19 decreased amount of prescribing, in those
20 doctors who were more experienced, right?

21 A. Yes.

22 Q. So to the extent you received
23 survey results, that was, at least, one of the
24 findings that you found, right?

25 A. Right.

1 MR. KEARSE: Object to form.

2 Q. I want you to turn, if you could,
3 just a couple of pages in, to the Discussion
4 section. Let met know when you are there.

5 A. Okay. Yep.

6 Q. This is, for the record, the Bates
7 number that ends 9798.

8 A. Yes.

9 Q. And you talk about some limitations
10 of the study, right?

11 I'm directing you to the paragraph
12 that begins, "Limitations to the study." It's
13 the final paragraph on this page.

14 A. Yes.

15 MR. KEARSE: I'm going to object to
16 form, and I think the doctor testified it is
17 not his paper. It is Dr. Thrasher's, just so
18 the record is clear.

19 Q. Is it your testimony that this
20 isn't yours?

21 A. Dr. Thrasher wrote it. I'm sure
22 that I looked at it, but he wrote it.

23 Q. I see. But these were the results
24 from the study that you and Dr. Thrasher
25 attempted to conduct, right?

1 A. Yes.

2 Q. And it says, "Limitations to this
3 study include the low response rate," and you
4 talked about that, "And the wording of the
5 questions"; do you see that?

6 A. Yes.

7 Q. What do you mean by that?

8 A. That, I think, we had a number of
9 responses on email as a question, like, "What
10 do you mean to this, what do you mean to that,"
11 which again, probably because we didn't have a
12 survey expert, you know, writing the questions,
13 so it was -- so again, another reason to say
14 are the results really of any value. It's
15 unclear. If you don't know what the question
16 means, if you answer it anyway, we can try to
17 interpret that as what we meant by the
18 question, but the doctor might not have
19 responded that way.

20 Q. And then about two-thirds in, do
21 you see the sentence that begins, "Attempting
22 to finish this study"?

23 A. Yes.

24 Q. It says, "Attempting to finish this
25 study in the time allotted during academic

1 semesters was also a limitation."

2 A. Uh-huh.

3 Q. What is that referring to?

4 A. I think the other person at NEOMED
5 might not have been a physician, but somebody
6 working on a Master's degree, who was helping
7 us, and the name escapes me because, of course,
8 we didn't publish it, so we don't have names on
9 it.

10 So they wanted to get the results
11 back in a short time. We were told there was a
12 particular technique, and I'm forgetting the
13 name of it, where if you send a survey out and
14 then you continue to send it out at a certain
15 interval, a certain number of times, I think it
16 was like seven times, in theory, under survey
17 expertise, that gets you some really high
18 response rate, by the time we get done with
19 that methodology, and we ended up cutting that
20 short, thereby not following that model, and
21 that may have accounted for our low response
22 rate.

23 Q. Okay. And this had to do with the
24 personal circumstances of a Master's degree
25 student?

1 A. Right. Who actually, quite
2 frankly, may have written this up, and then Dr.
3 Thrasher added to it, and then I basically, as
4 the recipient.

5 Q. The idea of writing up a draft like
6 this is to consider submitting it to a
7 peer-reviewed medical journal, correct?

8 MS. KEARSE: Object to form.

9 A. Well, in this case, the person
10 working the Master's degree had to come up
11 with -- had to do something as a -- to submit
12 to a board to get their Master's, but that does
13 not mean that we said, "Gee, we better submit
14 this to publication," because I don't think --
15 neither I nor Dr. Thrasher thought it would
16 stand up to peer-review scrutiny, because of
17 the limitations.

18 Q. The bottom line is, you don't
19 believe in the results of this particular
20 survey study that you tried to put together?

21 MR. KEARSE: Object to form.

22 A. Yeah. Correct. I, quite frankly,
23 soon thereafter kind of discounted it, and we
24 moved on.

25 Q. Okay. Did you discount it in part

1 because it didn't -- the results that you
2 received, whatever their limitations, didn't
3 match your preconceived hypothesis?

4 MS. KEARSE: Object to form.

5 A. No. That had nothing to do with
6 it. Just I was very disappointed that we
7 couldn't get a better response, when we thought
8 we were trying to do something good, that would
9 help us figure out what factors were playing
10 here, and given that, wasn't willing to put my
11 name or ADM's name on it and have it out there.

12 Q. Do you agree, as general matter,
13 that sometimes perceived factors, things that
14 are taken to be true or perceived to be true,
15 can be undermined by actual data, when studies
16 are actually performed?

17 MR. KEARSE: Object to form.

18 A. Can you repeat that.

19 Q. Sure. Do you agree that perceived
20 factors or perceived perceptions about what
21 might be true, even in medical science, can
22 sometimes be disproved by actual data?

23 MR. KEARSE: Object to form.

24 A. Certainly. Yeah. Medical science
25 changes all the time, based on new studies that

1 come out.

2 Q. And that's why it is important to
3 have reliable, sound, and, if possible,
4 peer-reviewed science to back up claims that
5 are made, fair?

6 MS. KEARSE: Object to form.

7 A. Yes. That's why we didn't publish
8 this.

9 MR. BOEHM: Thank you.

10 Anne, do you have any questions?

11 MR. KEARSE: I don't know. We will
12 have a break, and I'll let you know.

13 MR. BOEHM: Sounds good. Go off
14 the record.

15 THE VIDEOGRAPHER: Off the record
16 at 6:25.

17 (Recess taken.)

18 THE VIDEOGRAPHER: Back on the
19 record. The time is 6:26.

20 MR. KEARSE: I want that on the
21 record though.

22 MR. BOEHM: Happy to put that on
23 the record.

24 MR. KEARSE: The deposition is
25 closed. Thank you, Dr. Smith, for answering

1 questions of counsel today.

2 MR. BOEHM: Yes, we agree. Thank
3 you very much for your time today.

4 THE VIDEOGRAPHER: Off the record,
5 6:26.

6 (Deposition concluded at 6:26 p.m.)

7 - - - - -

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1 Whereupon, counsel was requested to give
2 instruction regarding the witness's review of
3 the transcript pursuant to the Civil Rules.

4
5 SIGNATURE:

6 Transcript review was requested pursuant to the
7 applicable Rules of Civil Procedure.

8
9 TRANSCRIPT DELIVERY:

10 Counsel was requested to give instruction
11 regarding delivery date of transcript.

REPORTER'S CERTIFICATE

The State of Ohio,)

SS:

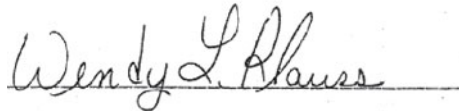
County of Cuyahoga.)

I, Wendy L. Klauss, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, DOUGLAS A. SMITH, M.D., DFAPA, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

1 I do further certify that I am not
2 a relative, counsel or attorney for either
3 party, or otherwise interested in the event of
4 this action.

5 IN WITNESS WHEREOF, I have hereunto
6 set my hand and affixed my seal of office at
7 Cleveland, Ohio, on this 21st day of
8 November, 2018.

9
10
11
12 
13

14 Wendy L. Klauss, Notary Public
15 within and for the State of Ohio
16

17 My commission expires July 13, 2019.
18
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Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

November 21, 2018

To: Anne Kearse

Case Name: In Re: National Prescription Opiate Litigation v.

Veritext Reference Number: 3112788

Witness: Douglas A. Smith, M.D., DFAPA Deposition Date:
11/16/2018

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown

above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3112788

CASE NAME: In Re: National Prescription Opiate Litigation v.

DATE OF DEPOSITION: 11/16/2018

WITNESS' NAME: Douglas A. Smith, M.D., DFAPA

In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
my testimony or it has been read to me.

I have made no changes to the testimony
as transcribed by the court reporter.

Date Douglas A. Smith, M.D., DFAPA

Sworn to and subscribed before me, a
Notary Public in and for the State and County,
the referenced witness did personally appear
and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn
Statement; and
Their execution of this Statement is of
their free act and deed.

I have affixed my name and official seal

this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3112788

CASE NAME: In Re: National Prescription Opiate Litigation v.

DATE OF DEPOSITION: 11/16/2018

WITNESS' NAME: Douglas A. Smith, M.D., DFAPA

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

Date

Douglas A. Smith, M.D., DFAPA

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

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ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 11/16/2018

PAGE/LINE(S) / CHANGE /REASON

Date Douglas A. Smith, M.D., DFAPA
SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20____ .

Notary Public

Commission Expiration Date

[& - 2006]

Page 1

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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